

SENATE No. 3012

The Commonwealth of Massachusetts

—————
In the One Hundred and Ninety-Third General Court
(2023-2024)
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SENATE, December 27, 2024

Report of the committee of conference on the disagreeing votes of the two branches with reference to the House amendment to the Senate relative to pharmaceutical access, costs and transparency (Senate, No. 2520) (amended by the House all after the enacting clause and inserting in place thereof the text of House document numbered 4910; and by striking out the title and inserting in place thereof the following title: “An Act promoting access and affordability of prescription drugs.”),-- reports, a “Bill relative to pharmaceutical access, costs and transparency” (Senate, No. 3012).

For the Committee:

Cindy F. Friedman
John J. Cronin

John J. Lawn, Jr.
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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:

1 SECTION 1. Section 1 of chapter 6D of the General Laws, as appearing in the 2022
2 Official Edition, is hereby amended by inserting after the definition of “Fiscal year” the
3 following definition:-

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

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

11 “Pharmaceutical manufacturing company”, an entity engaged in the: (i) production,
12 preparation, propagation, compounding, conversion or processing of prescription drugs, directly
13 or indirectly, by extraction from substances of natural origin, independently by means of

14 chemical synthesis or by a combination of extraction and chemical synthesis; or (ii) packaging,
15 repackaging, labeling, relabeling or distribution of prescription drugs; provided, however, that
16 “pharmaceutical manufacturing company” shall not include a hospital licensed under section 51
17 of chapter 111, a wholesale drug distributor licensed under section 36B of chapter 112 or a retail
18 pharmacist registered under section 39 of said chapter 112.

19 “Pharmacy benefit manager”, as defined in section 1 of chapter 176Y.

20 SECTION 3. Said chapter 6D is hereby further amended by inserting after section 3 the
21 following section:-

22 Section 3A. (a) There shall be within the commission an office for pharmaceutical policy
23 and analysis. The office shall: (i) analyze pharmaceutical spending data and information
24 collected by the commission and other agencies of the commonwealth pursuant to subsection (b);
25 (ii) produce reports and analyses of trends related to the access, affordability of and spending on
26 pharmaceutical drugs in the commonwealth pursuant to subsection (c); (iii) analyze records
27 related to pharmaceutical pricing disclosed to the commission pursuant to section 8A and assist
28 the commission in identifying proposed supplemental rebates for eligible drugs under said
29 section 8A; and (iv) advise the general court and state agencies on matters related to
30 pharmaceutical drug policy.

31 (b) The office shall analyze pharmaceutical spending data collected by the commission
32 and other agencies of the commonwealth, including pharmaceutical spending data collected by
33 the center under sections 8 to 10A, inclusive, of chapter 12C, and pharmaceutical spending data
34 available through publicly available sources. As part of its analysis, the office shall conduct an
35 annual survey of payers on pharmaceutical access and plan design, including tiering, cost-sharing

36 and other utilization management techniques employed by payers; provided, however, that any
37 confidential data shall not be a public record and shall be exempt from disclosure pursuant to
38 clause Twenty-sixth of section 7 of chapter 4 and section 10 of chapter 66.

39 (c)(1) The office shall produce an annual report on trends related to access, affordability
40 and spending on pharmaceutical drugs in the commonwealth and other reports from time to time.
41 The annual report shall address such trends and underlying factors for pharmaceutical drug
42 spending, including an analysis of trends in: (i) prices and utilization; (ii) drugs or categories of
43 drugs with the highest impact on spending; (iii) patient out-of-pocket spending; and (iv) access
44 and affordability issues for patients with rare diseases and chronic diseases; provided, however,
45 that any analysis pursuant to section 8A of a drug prescribed to treat a rare disease, or that is
46 otherwise designated as a first-in-class drug, shall be conducted pursuant to paragraph (3). The
47 report shall include any recommendations for strategies to mitigate pharmaceutical spending
48 growth, promote affordability and enhance pharmaceutical access.

49 (2) The annual report shall be based on factors, including, but not limited to: (i) drug
50 pricing; (ii) the impact of aggregate manufacturer rebates, discounts and other price concessions
51 on net drug pricing; (iii) patient cost-sharing such as deductibles, coinsurance, copayments or
52 similar charges paid by patients for drugs; (iv) the impact of aggregate rebates, discounts and
53 other price concessions on such cost-sharing; and (v) the impact of utilization management
54 techniques on pharmaceutical access employed by payers, including tiering, prior authorization
55 and step therapy. The annual report shall be informed by: (A) the office's analysis of information
56 provided at the annual cost trends hearing by providers, provider organizations and payers; (B)
57 data collected by the center under sections 8 to 10A, inclusive, of chapter 12C; and (C) any other

58 information available to the commission that is necessary to fulfill its duties under this section, as
59 further defined in regulations promulgated by the commission.

60 (3) The office shall consult with the rare disease advisory council established pursuant to
61 section 241 of chapter 111 and other stakeholders as determined by the office for any analysis
62 the office performs pursuant to section 8A of a drug that is prescribed to treat a rare disease or is
63 otherwise designated as a first-in-class drug by the United States Food and Drug
64 Administration's Center for Drug Evaluation and Research. Such analysis shall include:

65 (i) the disease treated by the drug;

66 (ii) the severity of disease treated by the drug;

67 (iii) the unmet medical need associated with the disease treated by the drug;

68 (iv) the impact of particular coverage, cost-sharing, tiering, utilization management, prior
69 authorization, medication therapy management or other utilization management policies on
70 access to the drug and on patients' adherence to the treatment regimen prescribed or otherwise
71 recommended by their health care provider;

72 (v) an assessment of the benefits and risks of the drug for patients;

73 (vi) whether patients who need treatment from or a consultation with a rare disease
74 specialist or a specialist in the disease being treated by the first-in-class drug have adequate
75 access and, if not, what factors are causing the limited access; and

76 (vii) the demographic and the clinical description of patient populations.

77 (4) Annually, but in no event later than September 1, the report shall be submitted to the
78 house and senate committees on ways and means and the joint committee on health care
79 financing and shall be published and made available to the public.

80 (d) The office shall analyze records related to pharmaceutical pricing disclosed to the
81 commission pursuant to section 8A and assist the commission in identifying proposed
82 supplemental rebates for eligible drugs under said section 8A. The office's analysis of such
83 records shall consider: (i) the effectiveness of the drug in treating the conditions for which it is
84 prescribed; (ii) improvements to a patient's health, quality of life or overall health outcomes; and
85 (iii) the likelihood that use of the drug will reduce the need for other medical care, including
86 hospitalization.

87 (e) The office may consult with external experts or other third-party entities when the
88 office lacks the specific scientific, medical or technical expertise necessary for the performance
89 of its responsibilities under this section; provided, however, that the commission shall disclose
90 when such external expert or third-party entity contributes to its analysis and reporting and the
91 identity of such external expert or third-party entity.

92 SECTION 4. Section 4 of said chapter 6D, as appearing in the 2022 Official Edition, is
93 hereby amended by striking out, in line 8, the word "manufacturers" and inserting in place
94 thereof the following words:- manufacturing companies, pharmacy benefit managers.

95 SECTION 5. Said chapter 6D is hereby further amended by striking out section 6, most
96 recently amended by section 5 of chapter 140 of the acts of 2024, and inserting in place thereof
97 the following section:-

98 Section 6. (a) For the purposes of this section, “non-hospital provider organization” shall
99 mean a provider organization required to register under section 11 that is: (i) a non-hospital-
100 based physician practice with not less than \$500,000,000 in annual gross patient service revenue;
101 (ii) a clinical laboratory; (iii) an imaging facility; or (iv) a network of affiliated urgent care
102 centers.

103 (b) Each acute hospital, ambulatory surgical center, non-hospital provider organization,
104 pharmaceutical manufacturing company and pharmacy benefit manager shall pay to the
105 commonwealth an amount for the estimated expenses of the commission.

106 (c) The assessed amount for acute hospitals, ambulatory surgical centers and non-hospital
107 provider organizations shall be not less than 30 per cent nor more than 40 per cent of the amount
108 appropriated by the general court for the expenses of the commission minus amounts collected
109 from: (i) filing fees; (ii) fees and charges generated by the commission; and (iii) federal matching
110 revenues received for these expenses or received retroactively for expenses of predecessor
111 agencies; provided, however, that, to the maximum extent permissible under federal law, non-
112 hospital provider organizations shall be assessed not less than 3 per cent nor more than 8 per cent
113 of the total assessed amount for acute hospitals, ambulatory surgical centers and non-hospital
114 provider organizations. Each acute hospital, ambulatory surgical center and non-hospital
115 provider organization shall pay such assessed amount multiplied by the ratio of the acute
116 hospital’s, ambulatory surgical center’s or non-hospital provider organization’s gross patient
117 service revenues to the total gross patient service revenues of all such hospitals, ambulatory
118 surgical centers and non-hospital provider organizations. Each acute hospital, ambulatory
119 surgical center and non-hospital provider organization shall make a preliminary payment to the
120 commission on October 1 of each year in an amount equal to 1/2 of the previous year’s total

121 assessment. Thereafter, each acute hospital, ambulatory surgical center and non-hospital provider
122 organization shall pay, within 30 days' notice from the commission, the balance of the total
123 assessment for the current year based upon its most current projected gross patient service
124 revenue. The commission shall subsequently adjust the assessment for any variation in actual and
125 estimated expenses of the commission and for changes in acute hospital, ambulatory surgical
126 center and non-hospital provider organization gross patient service revenue. Such estimated and
127 actual expenses shall include an amount equal to the cost of fringe benefits and indirect
128 expenses, as established by the comptroller under section 5D of chapter 29. In the event of late
129 payment by any such acute hospital, ambulatory surgical center or non-hospital provider
130 organization, the treasurer shall advance the amount of due and unpaid funds to the commission
131 prior to the receipt of such monies in anticipation of such revenues up to the amount authorized
132 in the then current budget attributable to such assessments and the commission shall reimburse
133 the treasurer for such advances upon receipt of such revenues. This section shall not apply to any
134 state institution or to any acute hospital which is operated by a city or town.

135 (d) To the maximum extent permissible under federal law, and provided that such
136 assessment will not result in any reduction of federal financial participation in Medicaid, the
137 assessed amount for pharmaceutical manufacturing companies shall be not less than 5 per cent
138 nor more than 10 per cent of the amount appropriated by the general court for the expenses of the
139 commission minus amounts collected from: (i) filing fees; (ii) fees and charges generated by the
140 commission; and (iii) federal matching revenues received for these expenses or received
141 retroactively for expenses of predecessor agencies. Each pharmaceutical manufacturing company
142 shall pay such assessed amount multiplied by the ratio of MassHealth's net spending for the

143 manufacturer's prescription drugs used in the MassHealth rebate program to MassHealth's total
144 pharmacy spending.

145 (e) To the maximum extent permissible under federal law, and provided that such
146 assessment will not result in any reduction of federal financial participation in Medicaid, the
147 assessed amount for pharmacy benefit managers shall be not less than 5 per cent nor more than
148 10 per cent of the amount appropriated by the general court for the expenses of the commission
149 minus amounts collected from: (i) filing fees; (ii) fees and charges generated by the commission;
150 and (iii) federal matching revenues received for these expenses or received retroactively for
151 expenses of predecessor agencies. Each pharmacy benefit manager shall pay such assessed
152 amount multiplied by the ratio of the claims paid by the pharmacy benefit manager attributed to
153 residents of the commonwealth for whom it manages pharmaceutical benefits on behalf of
154 carriers to the total of all such claims paid by all pharmacy benefit managers attributed to
155 residents of the commonwealth for whom they manage pharmaceutical benefits on behalf of
156 carriers.

157 (f) Each pharmaceutical manufacturing company and each pharmacy benefit manager
158 shall make a preliminary payment to the commission annually on October 1 in an amount equal
159 to 1/2 of the previous year's total assessment. Thereafter, each pharmaceutical manufacturing
160 company and each pharmacy benefit manager shall pay, within 30 days of receiving notice from
161 the commission, the balance of the total assessment for the current year as determined by the
162 commission.

163 SECTION 6. Subsection (a) of section 8 of said chapter 6D, as so appearing, is hereby
164 amended by striking out the second sentence and inserting in place thereof the following

165 sentence:- The hearings shall examine the costs, prices and cost trends of health care providers,
166 provider organizations, private and public health care payers, pharmaceutical manufacturing
167 companies and pharmacy benefit managers and any relevant impact of significant equity
168 investors, health care real estate investment trusts, management services organizations on such
169 costs, prices and cost trends, with particular attention to factors that contribute to cost growth
170 within the commonwealth's health care system and trends in annual primary care and behavioral
171 health expenditures.

172 SECTION 7. Said section 8 of said chapter 6D, as so appearing, is hereby further
173 amended by inserting after the word “payers” in line 16, the following words:- , significant
174 equity investors, health care real estate investment trusts, management services organizations,
175 pharmaceutical manufacturing companies, pharmacy benefit managers.

176 SECTION 8. Said section 8 of said chapter 6D, as so appearing, is hereby further
177 amended by striking out, in lines 29 through 34, inclusive, the words “(x) at least 4 provider
178 organizations, at least 2 of which shall be certified as accountable care organizations, 1 of which
179 has been certified as a model ACO, which shall be from diverse geographic regions of the
180 commonwealth; and (xi) any witness identified by the attorney general or the center” and
181 inserting in place thereof the following words:- (x) at least 4 provider organizations which shall
182 be from diverse geographic regions of the commonwealth, at least 2 of which shall be certified as
183 accountable care organizations and 1 of which shall be certified as a model ACO; (xi) any
184 significant equity investor, health care real estate investment trust or management services
185 organization associated with a provider or provider organization; (xii) a representative from the
186 division of insurance; (xiii) the executive director of the commonwealth health insurance
187 connector authority; (xiv) the assistant secretary for MassHealth; (xv) not less than 2

188 representatives of the pharmacy benefit management industry; (xvi) not less than 3
189 representatives of pharmaceutical manufacturing companies, 1 of whom shall be a representative
190 of a publicly traded company that manufactures specialty drugs, 1 of whom shall be a
191 representative of a company that manufactures generic drugs and 1 of whom shall be a
192 representative of a company that has been in existence for fewer than 10 years; and (xvii) any
193 witness identified by the attorney general or the center. The commission shall also request
194 testimony from officials representing the federal Centers for Medicare and Medicaid Services.

195 SECTION 9. Said section 8 of said chapter 6D, as so appearing, is hereby further
196 amended by striking out, in line 49, the first time it appears, the word “and”.

197 SECTION 10. Said section 8 of said chapter 6D, as so appearing, is hereby further
198 amended by inserting after the word “commission”, in line 60, the first time it appears, the
199 following words:- ; (iii) in the case of the assistant secretary for MassHealth, testimony
200 concerning the structure, benefits, eligibility, caseload and financing of MassHealth and other
201 Medicaid programs administered by the office of Medicaid or in partnership with other state and
202 federal agencies and the agency’s activities to align or redesign those programs in order to
203 encourage the development of more integrated and efficient health care delivery systems; (iv) in
204 the case of pharmacy benefit managers and pharmaceutical manufacturing companies, testimony
205 concerning factors underlying prescription drug costs and price increases, the impact of
206 aggregate manufacturer rebates, discounts and other price concessions on net pricing; provided,
207 however, that such testimony shall be suitable for public release and not likely to compromise
208 the financial, competitive or proprietary nature of any information or data; and (v) in the case of
209 significant equity investors, health care real estate investment trusts or management services
210 organization associated with a provider or provider organization, testimony concerning health

211 outcomes, prices charged to insurers and patients, staffing levels, clinical workflow, financial
212 stability and ownership structure of an associated provider or provider organization, dividends
213 paid out to investors, compensation including, but not limited to, base salaries, incentives,
214 bonuses, stock options, deferred compensations, benefits and contingent payments to officers,
215 managers and directors of provider organizations in the commonwealth acquired, owned or
216 managed, in whole or in part, by said significant equity investors, health care real estate
217 investment trusts or management services organizations.

218 SECTION 11. Said section 8 of said chapter 6D, as so appearing, is hereby further
219 amended by striking out subsection (g) and inserting in place thereof the following subsection:-

220 (g) The commission shall compile an annual report concerning spending trends, including
221 primary care and behavioral health expenditures, and the underlying factors influencing said
222 spending trends. The report shall be based on the commission's analysis of information provided
223 at the hearings by witnesses, providers, provider organizations and payers, registration data
224 collected pursuant to section 11, data collected or analyzed by the center pursuant to sections 8 to
225 10A, inclusive, of chapter 12C and any other available information that the commission
226 considers necessary to fulfill its duties under this section, as defined in regulations promulgated
227 by the commission. The report shall be submitted to the house and senate committees on ways
228 and means and the joint committee on health care financing and shall be published and available
229 to the public not later than December 31 of each year. The report shall include recommendations
230 for strategies to increase the efficiency of the health care system and promote affordability for
231 individuals and families, recommendations on the specific spending trends that impede the
232 commonwealth's ability to meet the health care cost growth benchmark and draft legislation
233 necessary to implement said recommendations.

234 SECTION 12. Section 9 of said chapter 6D, as so appearing, is hereby amended by
235 inserting after the word “organization”, in line 72, the following words:- , pharmacy benefit
236 manager, pharmaceutical manufacturing company.

237 SECTION 13. Said section 9 of said chapter 6D, as so appearing, is hereby further
238 amended by inserting after the word “organizations”, in line 82, the following words:- ,
239 pharmacy benefit managers, pharmaceutical manufacturing companies.

240 SECTION 14. Said chapter 6D is hereby further amended by inserting after section 22
241 the following section:-

242 Section 23. Every 2 years, the commission, in consultation with the center, the group
243 insurance commission, the office of Medicaid and the division of insurance, shall evaluate the
244 impact of section 17Z of chapter 32A, section 10Z of chapter 118E, section 47CCC of chapter
245 175, section 8DDD of chapter 176A, section 4DDD of chapter 176B and section 4VV of chapter
246 176G on the effects of capping co-payments on health care costs, including premiums,
247 pharmaceutical spending, aggregate rebates, cost-sharing, drug treatment utilization and
248 adherence, incidence of related acute events and health equity. Biennially, not later than
249 November 30, the commission shall file a report of its findings with the clerks of the house of
250 representatives and senate, the chairs of the joint committee on public health, the chairs of the
251 joint committee on health care financing and the chairs of house and senate committees on ways
252 and means.

253 SECTION 15. Section 1 of chapter 12C of the General Laws, as appearing in the 2022
254 Official Edition, is hereby amended by inserting after the definition of “Patient-centered medical
255 home” the following 3 definitions:-

256 “Payer”, any entity, other than an individual, that pays providers for the provision of
257 health care services; provided, however, that “payer” shall include both governmental and
258 private entities; and provided further, that “payer” shall include self-insured plans to the extent
259 allowed under the Employee Retirement Income Security Act of 1974.

260 “Pharmaceutical manufacturing company”, an entity engaged in the: (i) production,
261 preparation, propagation, compounding, conversion or processing of prescription drugs, directly
262 or indirectly, by extraction from substances of natural origin, independently by means of
263 chemical synthesis or by a combination of extraction and chemical synthesis; or (ii) packaging,
264 repackaging, labeling, relabeling or distribution of prescription drugs; provided, however, that
265 “pharmaceutical manufacturing company” shall not include a hospital licensed under section 51
266 of chapter 111, a wholesale drug distributor licensed under section 36B of chapter 112 or a retail
267 pharmacist registered under section 39 of said chapter 112.

268 “Pharmacy benefit manager”, as defined in section 1 of chapter 176Y.

269 SECTION 16. Said section 1 of said chapter 12C, as so appearing, is hereby further
270 amended by adding the following definition:-

271 “Wholesale acquisition cost”, the cost of a prescription drug as defined in 42 U.S.C.
272 1395w-3a(c)(6)(B).

273 SECTION 17. Section 3 of said chapter 12C, as so appearing, is hereby amended by
274 inserting after the word “organizations”, in lines 13 and 14, the following words:- ,
275 pharmaceutical manufacturing companies, pharmacy benefit managers.

276 SECTION 18. Said section 3 of said chapter 12C, as so appearing, is hereby further
277 amended by striking out, in line 24, the words “and payer” and inserting in place thereof the
278 following words:- , payer, pharmaceutical manufacturing company and pharmacy benefit
279 manager.

280 SECTION 19. Section 5 of said chapter 12C, as so appearing, is hereby amended by
281 inserting after the word “organizations”, in line 11, the following words:- , pharmacy benefit
282 managers, pharmaceutical manufacturing companies.

283 SECTION 20. Said section 5 of said chapter 12C, as so appearing, is hereby further
284 amended by striking out, in line 15, the words “and affected payers” and inserting in place
285 thereof the following words:- affected payers, affected pharmaceutical manufacturing companies
286 and affected pharmacy benefit managers.

287 SECTION 21. Said chapter 12C is hereby further amended by striking out section 7, as
288 amended by section 18 of chapter 140 of the acts of 2024, and inserting in place thereof the
289 following section:-

290 Section 7. (a) For the purposes of this section, “non-hospital provider organization” shall
291 mean a provider organization required to register under section 11 under chapter 6D that is: (i) a
292 non-hospital-based physician practice with not less than \$500,000,000 in annual gross patient
293 service revenue; (ii) a clinical laboratory; (iii) an imaging facility; or (iv) a network of affiliated
294 urgent care centers.

295 (b) Each acute hospital, ambulatory surgical center, non-hospital provider organization,
296 pharmaceutical manufacturing company and pharmacy benefit manager, shall pay to the
297 commonwealth an amount for the estimated expenses of the center and for the other purposes

298 described in this chapter which shall include any transfer made to the Community Hospital
299 Reinvestment Trust Fund established in section 2TTTT of chapter 29.

300 (c) The assessed amount for acute hospitals, ambulatory surgical centers and non-hospital
301 provider organizations shall be not less than 30 per cent nor more than 40 per cent of the amount
302 appropriated by the general court for the expenses of the center and for the other purposes
303 described in this chapter which shall include any transfer made to the Community Hospital
304 Reinvestment Trust Fund established in section 2TTTT of chapter 29 minus amounts collected
305 from: (i) filing fees; (ii) fees and charges generated by the center's publication or dissemination
306 of reports and information; and (iii) federal matching revenues received for these expenses or
307 received retroactively for expenses of predecessor agencies; provided, however, that, to the
308 maximum extent permissible under federal law, non-hospital provider organizations shall be
309 assessed not less than 3 per cent nor more than 8 per cent of the total assessed amount for acute
310 hospitals, ambulatory surgical centers and non-hospital provider organizations. Each acute
311 hospital, ambulatory surgical center and non-hospital provider organization shall pay such
312 assessed amount multiplied by the ratio of the acute hospital's, ambulatory surgical center's or
313 non-hospital provider organization's gross patient service revenues to the total gross patient
314 services revenues of all such hospitals, ambulatory surgical centers and non-hospital provider
315 organizations. Each acute hospital, ambulatory surgical center and non-hospital provider
316 organization shall make a preliminary payment to the center on October 1 of each year in an
317 amount equal to 1/2 of the previous year's total assessment. Thereafter, each acute hospital,
318 ambulatory surgical center and non-hospital provider organization shall pay, within 30 days'
319 notice from the center, the balance of the total assessment for the current year based upon its
320 most current projected gross patient service revenue. The center shall subsequently adjust the

321 assessment for any variation in actual and estimated expenses of the center and for changes in
322 acute hospital, ambulatory surgical center and non-hospital provider organization gross patient
323 service revenue. Such estimated and actual expenses shall include an amount equal to the cost of
324 fringe benefits and indirect expenses, as established by the comptroller under section 5D of
325 chapter 29. In the event of late payment by any such acute hospital, ambulatory surgical center or
326 non-hospital provider organization, the treasurer shall advance the amount of due and unpaid
327 funds to the center prior to the receipt of such monies in anticipation of such revenues up to the
328 amount authorized in the then current budget attributable to such assessments and the center shall
329 reimburse the treasurer for such advances upon receipt of such revenues. This section shall not
330 apply to any state institution or to any acute hospital which is operated by a city or town.

331 (d) To the maximum extent permissible under federal law, and provided that such
332 assessment will not result in any reduction of federal financial participation in Medicaid, the
333 assessed amount for pharmaceutical manufacturing companies shall be not less than 5 per cent
334 nor more than 10 per cent of the amount appropriated by the general court for the expenses of the
335 center minus amounts collected from: (i) filing fees; (ii) fees and charges generated by the
336 center's publication or dissemination of reports and information; and (iii) federal matching
337 revenues received for these expenses or received retroactively for expenses of predecessor
338 agencies. Each pharmaceutical manufacturing company shall pay such assessed amount
339 multiplied by the ratio of MassHealth's net spending for the manufacturer's prescription drugs
340 used in the MassHealth rebate program to MassHealth's total pharmacy spending.

341 (e) To the maximum extent permissible under federal law, and provided that such
342 assessment will not result in any reduction of federal financial participation in Medicaid, the
343 assessed amount for pharmacy benefit managers shall be not less than 5 per cent nor more than

344 10 per cent of the amount appropriated by the general court for the expenses of the center minus
345 amounts collected from: (i) filing fees; (ii) fees and charges generated by the center's publication
346 or dissemination of reports and information; and (iii) federal matching revenues received for
347 these expenses or received retroactively for expenses of predecessor agencies. Each pharmacy
348 benefit manager shall pay such assessed amount multiplied by the ratio of the claims paid by the
349 pharmacy benefit manager attributed to residents of the commonwealth for whom it manages
350 pharmaceutical benefits on behalf of carriers to the total of all such claims paid by all pharmacy
351 benefit managers attributed to residents of the commonwealth for whom they manage
352 pharmaceutical benefits on behalf of carriers.

353 (f) Each pharmaceutical manufacturing company and each pharmacy benefit manager
354 shall make a preliminary payment to the center annually on October 1 in an amount equal to 1/2
355 of the previous year's total assessment. Thereafter, each pharmaceutical manufacturing company
356 and each pharmacy benefit manager shall pay, within 30 days' notice from the center, the
357 balance of the total assessment for the current year as determined by the center.

358 SECTION 22. Said chapter 12C is hereby further amended by inserting after section 10
359 the following section:-

360 Section 10A. (a) The center shall promulgate regulations necessary to ensure the uniform
361 reporting of information from pharmacy benefit managers to enable the center to analyze: (i)
362 year-over-year changes in wholesale acquisition cost; (ii) year-over-year trends in formulary,
363 maximum allowable cost lists and cost-sharing design, including the establishment and
364 management of specialty product lists; (iii) aggregate information regarding discounts, utilization
365 limits, rebates, administrative fees charged to pharmaceutical manufacturing companies and

366 other financial incentives or concessions related to pharmaceutical products or formulary
367 programs; (iv) trends in estimated aggregate drug rebates and other aggregate drug price
368 reductions, if any, provided by a pharmacy benefit manager to a carrier client or health plan
369 sponsor or passed through from a pharmacy benefit manager to a carrier client or health plan
370 sponsor in connection with utilization of drugs in the commonwealth offered through the
371 pharmacy benefit manager and a measure of lives covered by each carrier client or health plan
372 sponsor in the commonwealth; and (v) any other information deemed reasonably necessary by
373 the center by regulation.

374 (b) The center shall require the submission of available data and other information from
375 pharmacy benefit managers including, but not limited to: (i) the aggregate amount of all rebates
376 that the pharmacy benefit manager received from all pharmaceutical manufacturing companies
377 and for all carrier clients or health plan sponsors; (ii) the administrative fees that the pharmacy
378 benefit manager received from all carrier clients or health plan sponsors in the aggregate and for
379 each carrier client or health plan sponsor individually; (iii) the aggregate amount of rebates a
380 pharmacy benefit manager: (A) retains based on its contractual arrangement with each carrier
381 client or health plan sponsor individually; and (B) passes through to each carrier client or health
382 plan sponsor individually; (iv) the aggregate amount of all retained rebates that the pharmacy
383 benefit manager received from all pharmaceutical manufacturing companies and did not pass
384 through to each pharmacy benefit manager's carrier client or health plan sponsor individually;
385 (v) the percentage of contracts that a pharmacy benefit manager holds where the pharmacy
386 benefit manager: (A) retains all rebates; (B) passes all rebates through to the carrier client or
387 health plan sponsor; and (C) shares rebates with the carrier client or health plan sponsor; and (vi)

388 information related to the pharmacy benefit manager practices of spread pricing, administrative
389 fees, claw backs and formulary placement.

390 (c) Except as specifically provided otherwise under this chapter, data collected by the
391 center pursuant to this section shall not be a public record under clause Twenty-sixth of section 7
392 of chapter 4 and section 10 of chapter 66. No such data shall be disclosed in a manner that is
393 likely to compromise the financial, competitive or proprietary nature of such data and other
394 information, or that may identify specific prices charged for drugs, the value of any rebate
395 amounts, individual drugs, or any pharmaceutical manufacturing company.

396 SECTION 23. Section 11 of said chapter 12C of the General Laws, as so appearing, is
397 hereby amended by striking out the first sentence and inserting in place thereof the following
398 sentence:- The center shall ensure the timely reporting of information required under sections 8
399 to 10A, inclusive.

400 SECTION 24. Section 12 of said chapter 12C, as appearing in the 2022 Official Edition,
401 is hereby amended by striking out, in line 2, the words “8, 9 and 10” and inserting in place
402 thereof the following words:- 8 to 10A, inclusive.

403 SECTION 25. Subsection (a) of section 16 of said chapter 12C, as so appearing, is hereby
404 amended by striking out the first sentence and inserting in place thereof the following sentence:-
405 The center shall publish an annual report based on the information submitted under: (i) sections 8
406 to 10A, inclusive, concerning health care provider, provider organization, private and public
407 health care payer, pharmaceutical manufacturing company and pharmacy benefit manager costs
408 and cost and price trends; (ii) section 13 of chapter 6D relative to cost and market impact
409 reviews; and (iii) section 15 relative to quality data.

410 SECTION 26. Chapter 32A of the General Laws is hereby amended by inserting after
411 section 17Y the following section:-

412 Section 17Z. (a) As used in this section, the following words shall have the following
413 meanings unless the context clearly requires otherwise:

414 “Brand name drug”, a drug that is: (i) produced or distributed pursuant to an original new
415 drug application approved under 21 U.S.C. 355(c) except for: (A) any drug approved through an
416 application submitted under section 505(b)(2) of the Federal Food, Drug, and Cosmetic Act that
417 is pharmaceutically equivalent, as that term is defined by the United States Food and Drug
418 Administration, to a drug approved under 21 U.S.C. 355(c); (B) an abbreviated new drug
419 application that was approved by the United States Secretary of Health and Human Services
420 under section 505(c) of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 355(c), before the
421 date of the enactment of the Drug Price Competition and Patent Term Restoration Act of 1984,
422 Public Law 98-417, 98 Stat. 1585; or (C) an authorized generic drug as defined in 42 C.F.R.
423 447.502; (ii) produced or distributed pursuant to a biologics license application approved under
424 42 U.S.C. 262(a)(2)(C); or (iii) identified by the health benefit plan as a brand name drug based
425 on available data resources, including Medi-Span.

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

431 (b) The commission shall identify 1 generic drug and 1 brand name drug used to treat
432 each of the following chronic conditions: (i) diabetes; (ii) asthma; and (iii) the 2 most prevalent
433 heart conditions among its members.

434 (c) The commission shall identify insulin as the drug used to treat diabetes. In
435 determining the 1 generic drug and 1 brand name drug used to treat each chronic condition, the
436 commission shall consider whether the drug is:

437 (i) of clear benefit and strongly supported by clinical evidence;

438 (ii) likely to: (A) reduce hospitalizations or emergency department visits; (B) reduce
439 future exacerbations of illness progression; or (C) improve quality of life; (iii) cost effective for
440 the commission and its members; (iv) at low risk for overutilization, abuse, addiction, diversion
441 or fraud; and (v) one of the most widely utilized as a treatment for the chronic condition.

442 (d) The commission shall provide coverage for the brand name drugs and generic drugs
443 identified pursuant to subsection (b). Coverage for the identified generic drugs shall not be
444 subject to any cost-sharing, including co-payments and co-insurance, and shall not be subject to
445 any deductible; provided, however, that cost-sharing shall be required if the applicable plan is
446 governed by the Internal Revenue Code and would lose its tax-exempt status as a result of the
447 prohibition on cost-sharing under this section. Coverage for the identified brand name drugs shall
448 not be subject to any deductible or co-insurance and any co-payment shall not exceed \$25 per
449 30-day supply. Coverage for 1 brand name insulin drug per dosage and type, including rapid-
450 acting, short-acting, intermediate-acting, long-acting, ultra long-acting and premixed under this
451 section shall not be subject to any deductible or co-insurance and any co-payment shall not
452 exceed \$25 per 30-day supply.

453 (e) The commission shall implement a continuity of coverage policy to apply to members
454 that are new to the commission and that provides coverage for a 30-day fill of a United States
455 Food and Drug Administration-approved drug reimbursed through a pharmacy benefit that the
456 member has already been prescribed and on which the member is stable, upon documentation by
457 the member's prescriber; provided, however, that the commission shall not apply any greater
458 deductible, coinsurance, copayments or out-of-pocket limits than would otherwise apply to other
459 drugs covered by the plan.

460 (f) The commission may make changes in its selection of drugs pursuant to this section
461 not more than annually.

462 (g) The commission shall make public the drugs selected pursuant to subsection (b).

463 SECTION 27. Chapter 94C of the General Laws is hereby amended by inserting after
464 section 21B the following section:-

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

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

469 "Health benefit plan", as defined in section 1 of chapter 176O.

470 "Pharmacy benefit manager", as defined in section 1 of chapter 176Y.

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

474 (b) At the point of sale, a pharmacy shall charge an individual for a prescription drug the
475 lesser of: (i) the applicable cost-sharing amount; or (ii) the pharmacy retail price.

476 (c) A health benefit plan or carrier shall not require an insured to make a cost-sharing
477 payment for a prescription drug in an amount greater than that charged pursuant to subsection
478 (b).

479 (d) No contractual obligation between a pharmacy benefit manager and a pharmacist shall
480 prohibit a pharmacist from complying with this section.

481 SECTION 28. Chapter 118E of the General Laws is hereby amended by inserting after
482 section 10Y the following section:-

483 Section 10Z. (a) As used in this section, the following words shall have the following
484 meanings unless the context clearly requires otherwise:

485 “Brand name drug”, a drug that is: (i) produced or distributed pursuant to an original new
486 drug application approved under 21 U.S.C. 355(c) except for: (A) any drug approved through an
487 application submitted under section 505(b)(2) of the Federal Food, Drug, and Cosmetic Act that
488 is pharmaceutically equivalent, as that term is defined by the United States Food and Drug
489 Administration, to a drug approved under 21 U.S.C. 355(c); (B) an abbreviated new drug
490 application that was approved by the United States Secretary of Health and Human Services
491 under section 505(c) of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 355(c), before the
492 date of the enactment of the Drug Price Competition and Patent Term Restoration Act of 1984,
493 Public Law 98-417, 98 Stat. 1585; or (C) an authorized generic drug as defined in 42 C.F.R.
494 447.502; (ii) produced or distributed pursuant to a biologics license application approved under

495 42 U.S.C. 262(a)(2)(C); or (iii) identified by the health benefit plan as a brand name drug based
496 on available data resources, including Medi-Span.

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

502 (b) The division shall identify 1 generic drug and 1 brand name drug used to treat each of
503 the following chronic conditions: (i) diabetes; (ii) asthma; and (iii) the 2 most prevalent heart
504 conditions among its enrollees.

505 (c) The division shall identify insulin as the drug used to treat diabetes. In determining
506 the 1 generic drug and 1 brand name drug used to treat each chronic condition, the division shall
507 consider whether the drug is:

508 (i) of clear benefit and strongly supported by clinical evidence;

509 (ii) likely to: (A) reduce hospitalizations or emergency department visits; (B) reduce
510 future exacerbations of illness progression; or (C) improve quality of life;

511 (iii) cost effective for the division and its enrollees;

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

513 (v) one of the most widely utilized as a treatment for the chronic condition.

514 (d) The division and its contracted health insurers, health plans, health maintenance
515 organizations, behavioral health management firms and third-party administrators under contract
516 to a Medicaid managed care organization or primary care clinician plan shall provide coverage
517 for the brand name drugs and generic drugs identified pursuant to subsection (b). Coverage for
518 the identified generic drugs shall not be subject to any cost-sharing, including co-payments and
519 co-insurance, and shall not be subject to any deductible. Coverage for identified brand name
520 drugs shall not be subject to any deductible or co-insurance and any co-payment shall not exceed
521 \$25 per 30-day supply. Coverage for 1 brand name insulin drug per dosage and type, including
522 rapid-acting, short-acting, intermediate-acting, long-acting, ultra long-acting and premixed under
523 this section shall not be subject to any deductible or co-insurance and any co-payment shall not
524 exceed \$25 per 30-day supply.

525 (e) This section shall not apply to health plans providing coverage in the senior care
526 options program to MassHealth-only members who are age 65 or older.

527 (f) The division shall implement a continuity of coverage policy that apply to enrollees
528 that are new to the Medicaid program and that provides coverage for a 30-day fill of a United
529 States Food and Drug Administration-approved drug reimbursed through a pharmacy benefit that
530 the enrollee has already been prescribed and on which the enrollee is stable, upon documentation
531 by the enrollee's prescriber; provided, however, that the division shall not apply any greater
532 deductible, coinsurance, copayments or out-of-pocket limits than would otherwise apply to other
533 drugs covered by the plan.

534 (g) The division may make changes in its selection of drugs pursuant to this section not
535 more than annually.

536 (h) The division shall make public the drugs selected pursuant to subsection (b).

537 SECTION 29. Section 64 of said chapter 118E is hereby amended by striking out the
538 definition of “Center for health information and analysis revenue amount”, inserted by section
539 120 of chapter 140 of the acts of 2024, and inserting in place thereof the following definition:-

540 “Center for health information and analysis revenue amount”, an amount equal to the
541 sum of the amount collected by the center for health information and analysis from acute
542 hospitals, ambulatory surgical centers and non-hospital provider organizations pursuant to
543 section 7 of chapter 12C.

544 SECTION 30. Said section 64 of said chapter 118E is hereby further amended by striking
545 out the definition “Health policy commission revenue amount”, inserted by section 121 of said
546 chapter 140, and inserting in place thereof the following definition:-

547 “Health policy commission revenue amount”, the amount collected by the health policy
548 commission from acute hospitals, ambulatory surgical centers and non-hospital provider
549 organizations pursuant to section 6 of chapter 6D.

550 SECTION 31. Chapter 175 of the General Laws is hereby amended by inserting after
551 section 47BBB the following section:-

552 Section 47CCC. (a) As used in this section, the following words shall have the following
553 meanings unless the context clearly requires otherwise:

554 “Brand name drug”, a drug that is: (i) produced or distributed pursuant to an original new
555 drug application approved under 21 U.S.C. 355(c) except for: (A) any drug approved through an
556 application submitted under section 505(b)(2) of the Federal Food, Drug, and Cosmetic Act that

557 is pharmaceutically equivalent, as that term is defined by the United States Food and Drug
558 Administration, to a drug approved under 21 U.S.C. 355(c); (B) an abbreviated new drug
559 application that was approved by the United States Secretary of Health and Human Services
560 under section 505(c) of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 355(c), before the
561 date of the enactment of the Drug Price Competition and Patent Term Restoration Act of 1984,
562 Public Law 98-417, 98 Stat. 1585; or (C) an authorized generic drug as defined in 42 C.F.R.
563 447.502; (ii) produced or distributed pursuant to a biologics license application approved under
564 42 U.S.C. 262(a)(2)(C); or (iii) identified by the health benefit plan as a brand name drug based
565 on available data resources, including Medi-Span.

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

571 (b) Any policy, contract, agreement, plan or certificate of insurance issued, delivered or
572 renewed within the commonwealth and which is considered creditable coverage under section 1
573 of chapter 111M shall identify 1 generic drug and 1 brand name drug used to treat each of the
574 following chronic conditions: (i) diabetes; (ii) asthma; and (iii) the 2 most prevalent heart
575 conditions among its enrollees.

576 (c) The carrier shall identify insulin as the drug used to treat diabetes. In determining the
577 1 generic drug and 1 brand name drug used to treat each chronic condition, the carrier shall
578 consider whether the drug is:

579 (i) of clear benefit and strongly supported by clinical evidence;

580 (ii) likely to: (A) reduce hospitalizations or emergency department visits; (B) reduce
581 future exacerbations of illness progression; or (C) improve quality of life;

582 (iii) cost effective for the carrier and its enrollees;

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

584 (v) one of the most widely utilized as a treatment for the chronic condition.

585 (d) Any such policy, contract, agreement, plan or certificate of insurance issued,
586 delivered or renewed within the commonwealth, which is considered creditable coverage under
587 section 1 of chapter 111M, shall provide coverage for the brand name drugs and generic drugs
588 identified pursuant to subsection (b). Coverage for the identified generic drugs shall not be
589 subject to cost-sharing, including co-payments and co-insurance, and shall not be subject to any
590 deductible; provided, however, that cost-sharing shall be required if the applicable plan is
591 governed by the Internal Revenue Code and would lose its tax-exempt status as a result of the
592 prohibition on cost-sharing under this section. Coverage for identified brand name drugs shall
593 not be subject to any deductible or co-insurance and any co-payment shall not exceed \$25 per
594 30-day supply. Coverage for 1 brand name insulin drug per dosage and type, including rapid-
595 acting, short-acting, intermediate-acting, long-acting, ultra long-acting and premixed under this
596 section shall not be subject to any deductible or co-insurance and any co-payment shall not
597 exceed \$25 per 30-day supply.

598 (e) The carrier shall implement a continuity of coverage policy to apply to enrollees that
599 are new to the carrier and that provides coverage for a 30-day fill of a United States Food and

600 Drug Administration-approved drug reimbursed through a pharmacy benefit that the enrollee has
601 already been prescribed and on which the enrollee is stable, upon documentation by the
602 enrollee’s prescriber; provided, however, that a carrier shall not apply any greater deductible,
603 coinsurance, copayments or out-of-pocket limits than would otherwise apply to other drugs
604 covered by the plan.

605 (f) The carrier may make changes in its selection of drugs pursuant to this section not
606 more than annually.

607 (g) The carrier shall make public the drugs selected pursuant to subsection (b).

608 SECTION 32. Section 226 of said chapter 175, as appearing in the 2022 Official Edition,
609 is hereby amended by striking out, in line 81, the word “may” and inserting in place thereof the
610 following word:- shall.

611 SECTION 33. Chapter 176A of the General Laws is hereby amended by inserting after
612 8CCC the following section:-

613 Section 8DDD. (a) As used in this section, the following words shall have the following
614 meanings unless the context clearly requires otherwise:

615 “Brand name drug”, a drug that is: (i) produced or distributed pursuant to an original new
616 drug application approved under 21 U.S.C. 355(c) except for: (A) any drug approved through an
617 application submitted under section 505(b)(2) of the Federal Food, Drug, and Cosmetic Act that
618 is pharmaceutically equivalent, as that term is defined by the United States Food and Drug
619 Administration, to a drug approved under 21 U.S.C. 355(c); (B) an abbreviated new drug
620 application that was approved by the United States Secretary of Health and Human Services

621 under section 505(c) of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 355(c), before the
622 date of the enactment of the Drug Price Competition and Patent Term Restoration Act of 1984,
623 Public Law 98-417, 98 Stat. 1585; or (C) an authorized generic drug as defined in 42 C.F.R.
624 447.502; (ii) produced or distributed pursuant to a biologics license application approved under
625 42 U.S.C. 262(a)(2)(C); or (iii) identified by the health benefit plan as a brand name drug based
626 on available data resources, including Medi-Span.

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

632 (b) Any contract between a subscriber and the corporation under an individual or group
633 hospital service plan that is delivered, issued or renewed within the commonwealth shall identify
634 1 generic drug and 1 brand name drug used to treat each of the following chronic conditions: (i)
635 diabetes; (ii) asthma; and (iii) the 2 most prevalent heart conditions among its enrollees.

636 (c) The carrier shall identify insulin as the drug used to treat diabetes. In determining the
637 1 generic drug and 1 brand name drug used to treat each chronic condition, the carrier shall
638 consider whether the drug is:

639 (i) of clear benefit and strongly supported by clinical evidence;

640 (ii) likely to: (A) reduce hospitalizations or emergency department visits; (B) reduce
641 future exacerbations of illness progression; or (C) improve quality of life;

- 642 (iii) cost effective for the carrier and its enrollees;
- 643 (iv) at low risk for overutilization, abuse, addiction, diversion or fraud; and
- 644 (v) one of the most widely utilized as a treatment for the chronic condition.

645 (d) Any contract between a subscriber and the corporation under an individual or group
646 hospital service plan that is delivered, issued or renewed within the commonwealth shall provide
647 coverage for the brand name drugs and generic drugs identified pursuant to subsection (b).
648 Coverage for the identified generic drugs shall not be subject to cost-sharing, including co-
649 payments and co-insurance, and shall not be subject to any deductible; provided, however, that
650 cost-sharing shall be required if the applicable plan is governed by the Internal Revenue Code
651 and would lose its tax-exempt status as a result of the prohibition on cost-sharing under this
652 section. Coverage for identified brand name drugs shall not be subject to any deductible or co-
653 insurance and any co-payment shall not exceed \$25 per 30-day supply. Coverage for 1 brand
654 name insulin drug per dosage and type, including rapid-acting, short-acting, intermediate-acting,
655 long-acting, ultra long-acting and premixed under this section shall not be subject to any
656 deductible or co-insurance and any co-payment shall not exceed \$25 per 30-day supply.

657 (e) The carrier shall implement a continuity of coverage policy to apply to enrollees that
658 are new to the plan and that provides coverage for a 30-day fill of a United States Food and Drug
659 Administration-approved drug reimbursed through a pharmacy benefit that the enrollee has
660 already been prescribed and on which the enrollee is stable, upon documentation by the
661 enrollee's prescriber; provided, however, that a carrier shall not apply any greater deductible,
662 coinsurance, copayments or out-of-pocket limits than would otherwise apply to other drugs
663 covered by the plan.

664 (f) The carrier may make changes in its selection of drugs pursuant to this section not
665 more than annually.

666 (g) The carrier shall make public the drugs selected pursuant to subsection (b).

667 SECTION 34. Chapter 176B of the General Laws is hereby amended by inserting after
668 section 4CCC the following section:-

669 Section 4DDD. (a) As used in this section, the following words shall have the following
670 meanings unless the context clearly requires otherwise:

671 “Brand name drug”, a drug that is: (i) produced or distributed pursuant to an original new
672 drug application approved under 21 U.S.C. 355(c) except for: (A) any drug approved through an
673 application submitted under section 505(b)(2) of the Federal Food, Drug, and Cosmetic Act that
674 is pharmaceutically equivalent, as that term is defined by the United States Food and Drug
675 Administration, to a drug approved under 21 U.S.C. 355(c); (B) an abbreviated new drug
676 application that was approved by the United States Secretary of Health and Human Services
677 under section 505(c) of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 355(c), before the
678 date of the enactment of the Drug Price Competition and Patent Term Restoration Act of 1984,
679 Public Law 98-417, 98 Stat. 1585; or (C) an authorized generic drug as defined in 42 C.F.R.
680 447.502; (ii) produced or distributed pursuant to a biologics license application approved under
681 42 U.S.C. 262(a)(2)(C); or (iii) identified by the health benefit plan as a brand name drug based
682 on available data resources, including Medi-Span.

683 “Generic drug”, a retail drug that is: (i) marketed or distributed pursuant to an
684 abbreviated new drug application approved under 21 U.S.C. 355(j); (ii) an authorized generic
685 drug as defined in 42 C.F.R. 447.502; (iii) a drug that entered the market before January 1, 1962

686 and was not originally marketed under a new drug application; or (iv) identified by the health
687 benefit plan as a generic drug based on available data resources, including Medi-Span.

688 (b) A subscription certificate under an individual or group medical service agreement
689 delivered, issued or renewed within the commonwealth shall identify 1 generic drug and 1 brand
690 name drug used to treat each of the following chronic conditions: (i) diabetes; (ii) asthma; and
691 (iii) the 2 most prevalent heart conditions among its enrollees.

692 (c) The carrier shall identify insulin as the drug used to treat diabetes. In determining the
693 1 generic drug and 1 brand name drug used to treat each chronic condition, the carrier shall
694 consider whether the drug is:

695 (i) of clear benefit and strongly supported by clinical evidence;

696 (ii) likely to: (A) reduce hospitalizations or emergency department visits; (B) reduce
697 future exacerbations of illness progression; or (C) improve quality of life;

698 (iii) cost effective for the carrier and its enrollees;

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

700 (v) one of the most widely utilized as a treatment for the chronic condition.

701 (d) A subscription certificate under an individual or group medical service agreement
702 delivered, issued or renewed within the commonwealth shall provide coverage for the brand
703 name drugs and generic drugs identified pursuant to subsection (b). Coverage for the identified
704 generic drugs shall not be subject to any cost-sharing, including co-payments and co-insurance
705 and shall not be subject to any deductible; provided, however, that cost-sharing shall be required
706 if the applicable plan is governed by the Internal Revenue Code and would lose its tax-exempt

707 status as a result of the prohibition on cost-sharing under this section. Coverage for identified
708 brand name drugs shall not be subject to any deductible or co-insurance and any co-payment
709 shall not exceed \$25 per 30-day supply. Coverage for 1 brand name insulin drug per dosage and
710 type, including rapid-acting, short-acting, intermediate-acting, long-acting, ultra long-acting and
711 premixed under this section shall not be subject to any deductible or co-insurance and any co-
712 payment shall not exceed \$25 per 30-day supply.

713 (e) The carrier shall implement a continuity of coverage policy to apply to enrollees that
714 are new to the plan and that provides coverage for a 30-day fill of a United States Food and Drug
715 Administration-approved drug reimbursed through a pharmacy benefit that the enrollee has
716 already been prescribed and on which the enrollee is stable, upon documentation by the
717 enrollee's prescriber; provided, however, that a carrier shall not apply any greater deductible,
718 coinsurance, copayments or out-of-pocket limits than would otherwise apply to other drugs
719 covered by the plan.

720 (f) The carrier may make changes in its selection of drugs pursuant to this section not
721 more than annually.

722 (g) The carrier shall make public the drugs selected pursuant to subsection (b).

723 SECTION 35. Chapter 176G of the General Laws is hereby amended by inserting after
724 section 4UU the following section:-

725 Section 4VV. (a) As used in this section, the following words shall have the following
726 meanings unless the context clearly requires otherwise:

727 “Brand name drug”, a drug that is: (i) produced or distributed pursuant to an original new
728 drug application approved under 21 U.S.C. 355(c) except for: (A) any drug approved through an
729 application submitted under section 505(b)(2) of the Federal Food, Drug, and Cosmetic Act that
730 is pharmaceutically equivalent, as that term is defined by the United States Food and Drug
731 Administration, to a drug approved under 21 U.S.C. 355(c); (B) an abbreviated new drug
732 application that was approved by the United States Secretary of Health and Human Services
733 under section 505(c) of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 355(c), before the
734 date of the enactment of the Drug Price Competition and Patent Term Restoration Act of 1984,
735 Public Law 98-417, 98 Stat. 1585; or (C) an authorized generic drug as defined in 42 C.F.R.
736 447.502; (ii) produced or distributed pursuant to a biologics license application approved under
737 42 U.S.C. 262(a)(2)(C); or (iii) identified by the health benefit plan as a brand name drug based
738 on available data resources, including Medi-Span.

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

744 (b) An individual group health maintenance contract that is issued or renewed within or
745 without the commonwealth shall identify 1 generic drug and 1 brand name drug used to treat
746 each of the following chronic conditions: (i) diabetes; (ii) asthma; and (iii) the 2 most prevalent
747 heart conditions among its enrollees.

748 (c) The carrier shall identify insulin as the drug used to treat diabetes. In determining the
749 1 generic drug and 1 brand name drug used to treat each chronic condition, the carrier shall
750 consider whether the drug is:

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

752 (ii) likely to: (A) reduce hospitalizations or emergency department visits; (B) reduce
753 future exacerbations of illness progression; or (C) improve quality of life;

754 (iii) cost effective for the carrier and its enrollees;

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

756 (v) one of the most widely utilized as a treatment for the chronic condition.

757 (d) An individual group health maintenance contract that is issued or renewed within or
758 without the commonwealth shall provide coverage for the brand name drugs and generic drugs
759 identified pursuant to subsection (b). Coverage for the identified generic drugs shall not be
760 subject to cost-sharing, including co-payments and co-insurance and shall not be subject to any
761 deductible; provided, however, that cost-sharing shall be required if the applicable plan is
762 governed by the Internal Revenue Code and would lose its tax-exempt status as a result of the
763 prohibition on cost-sharing under this section. Coverage for identified brand name drugs shall
764 not be subject to any deductible or co-insurance and any co-payment shall not exceed \$25 per
765 30-day supply. Coverage for 1 brand name insulin drug per dosage and type, including rapid-
766 acting, short-acting, intermediate-acting, long-acting, ultra long-acting and premixed under this
767 section shall not be subject to any deductible or co-insurance and any co-payment shall not
768 exceed \$25 per 30-day supply.

769 (e) The carrier shall implement a continuity of coverage policy to apply to enrollees that
770 are new to the plan and that provides coverage for a 30-day fill of a United States Food and Drug
771 Administration-approved drug reimbursed through a pharmacy benefit that the enrollee has
772 already been prescribed and on which the enrollee is stable, upon documentation by the
773 enrollee's prescriber; provided, however, that a carrier shall not apply any greater deductible,
774 coinsurance, copayments or out-of-pocket limits than would otherwise apply to other drugs
775 covered by the plan.

776 (f) The carrier may make changes in its selection of drugs pursuant to this section not
777 more than annually.

778 (g) The carrier shall make public the drugs selected pursuant to subsection (b).

779 SECTION 36. Chapter 176O of the General Laws is hereby amended by adding the
780 following section:-

781 Section 30. (a) On an annual basis, each carrier shall report to the division the drugs
782 selected to be provided with no or limited cost-sharing under section 47CCC of chapter 175,
783 section 8DDD of chapter 176A, section 4DDD of chapter 176B and section 4VV of chapter
784 176G. The commissioner shall review the drugs to verify that the selected drugs meet the criteria
785 identified in those sections. Should a selected drug be deemed by the commissioner to not meet
786 the criteria, the commissioner may require a different drug to be selected. The commissioner
787 shall disclose the list of drugs selected by each entity annually on the division's website.

788 SECTION 37. The General Laws are hereby amended by inserting after chapter 176X the
789 following chapter:-

790

CHAPTER 176Y

791

LICENSING AND REGULATION OF PHARMACY BENEFIT MANAGERS.

792

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

793

unless the context clearly requires otherwise:

794

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

795

“Center”, the center for health information and analysis established in chapter 12C.

796

“Commissioner”, the commissioner of insurance.

797

“Division”, the division of insurance.

798

“Health benefit plan”, a contract, certificate or agreement entered into, offered or issued

799

by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care

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services; provided, however, that the commissioner may by regulation define other health

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coverage as a “health benefit plan” for the purposes of this chapter.

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

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“Mail-order pharmacy”, a pharmacy whose primary business is to receive prescriptions

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by mail, telefax or through electronic submissions and to dispense medication to insureds

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through the use of the United States mail or other common or contract carrier services.

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“Pharmacy”, a physical or electronic facility under the direction or supervision of a

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registered pharmacist that is authorized to dispense prescription drugs and has entered into a

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network contract with a pharmacy benefit manager or a carrier.

809 “Pharmacy benefit management services”, services performed by a pharmacy benefit
810 manager, including: (i) negotiating the price of prescription drugs, including negotiating and
811 contracting for direct or indirect rebates, discounts or other price concessions; (ii) managing any
812 aspects of a prescription drug benefit, including, but not limited to, formulary administration,
813 mail-order pharmacy and specialty drug pharmacy services, clinical, safety and adherence
814 programs for pharmacy service, the processing and payment of claims for prescription drugs,
815 arranging alternative access to or funding for prescription drugs, the performance of drug
816 utilization review, the processing of drug prior authorization requests, the adjudication of appeals
817 or grievances related to the prescription drug benefit, contracting with network pharmacies,
818 controlling the cost of covered prescription drugs and managing or providing data relating to the
819 prescription drug benefit or the provision of services related thereto; (iii) performance of any
820 administrative, managerial, clinical, pricing, financial, reimbursement, data administration or
821 reporting or billing service related to a health benefit plan’s prescription drug benefit; and (iv)
822 such other services as the division may define in regulation.

823 “Pharmacy benefit manager”, a person, business or other entity, however organized, that
824 directly or through a subsidiary provides pharmacy benefit management services for prescription
825 drugs and devices on behalf of a health benefit plan sponsor, including, but not limited to, a self-
826 insurance plan, labor union or other third-party payer; provided, however, that “pharmacy benefit
827 manager” shall not include a health benefit plan sponsor unless otherwise specified by the
828 division.

829 Section 2. (a) No person, business or other entity shall establish or operate as a pharmacy
830 benefit manager without obtaining a license from the division pursuant to this section. A license
831 may be granted only when the division is satisfied that the entity possesses the necessary

832 organization, background expertise financial integrity to supply the services sought to be offered.
833 A pharmacy benefit manager license shall be valid for a period of 3 years and shall be renewable
834 for additional 3-year periods. The commissioner shall charge application and renewal fees in the
835 amount of \$25,000.

836 (b) A license granted pursuant to this section and any rights or interests therein shall not
837 be transferable.

838 (c) A person, business or other entity licensed as a pharmacy benefit manager shall
839 submit data and reporting information to the center according to the standards and methods
840 specified by the center pursuant to section 10A of chapter 12C.

841 (d) The division may issue or renew a license pursuant to this section, subject to
842 restrictions in order to protect the interests of consumers. Such restrictions may include: (i)
843 limiting the type of services that a license holder may provide or (ii) limiting the activities in
844 which the license holder may be engaged.

845 (e) The division shall develop an application for licensure of pharmacy benefit managers
846 that shall include, but not be limited to: (i) the name of the applicant or pharmacy benefit
847 manager; (ii) the address and contact telephone number for the applicant or pharmacy benefit
848 manager; (iii) the name and address of the agent of the applicant or pharmacy benefit manager
849 for service of process in the commonwealth; (iv) the name and address of any person with
850 management or control over the applicant or pharmacy benefit manager; and (v) any audited
851 financial statements specific to the applicant or pharmacy benefit manager. An applicant or
852 pharmacy benefit manager shall report to the division any material change to the information

853 contained in its application, certified by an officer of the pharmacy benefit manager, within 30
854 days of such a change.

855 (f) The division may suspend, revoke, refuse to issue or renew or place on probation a
856 pharmacy benefit manager license for cause, which shall include, but not be limited to: (i) the
857 applicant or pharmacy benefit manager engaging in fraudulent activity that is found by a court of
858 law to be a violation of state or federal law; (ii) the division receiving consumer complaints that
859 justify an action under this chapter to protect the health, safety and interests of consumers; (iii)
860 the applicant or pharmacy benefit manager failing to pay an application or renewal fee for a
861 license; (iv) the applicant or pharmacy benefit manager failing to comply with reporting
862 requirements of the center under section 10A of chapter 12C; or (v) the applicant pharmacy
863 benefit manager's failing to comply with a requirement of this chapter.

864 The division shall provide written notice to the applicant or pharmacy benefit manager
865 and advise in writing of the reason for any suspension, revocation, refusal to issue or renew or
866 placement on probation of a pharmacy benefit manager license under this chapter. A copy of the
867 notice shall be forwarded to the center. The applicant or pharmacy benefit manager may make
868 written demand upon the division within 30 days of receipt of such notification for a hearing
869 before the division to determine the reasonableness of the division's action. The hearing shall be
870 held pursuant to chapter 30A.

871 The division shall not suspend or cancel a license unless the division has first afforded
872 the pharmacy benefit manager an opportunity for a hearing pursuant to said chapter 30A.

873 (g) If a person, business or other entity performs the functions of a pharmacy benefit
874 manager in violation of this chapter, the person, business or other entity shall be subject to a fine
875 of \$5,000 per day for each day that the person, business or other entity is found to be in violation.

876 (h) A pharmacy benefit manager that violates this chapter or any rule or regulation
877 promulgated pursuant to this chapter shall be subject to a fine of not less than \$5,000 for each
878 violation.

879 (i) A pharmacy benefit manager licensed under this section shall notify a carrier client in
880 writing of any activity, policy, practice contract or arrangement of the pharmacy benefit manager
881 that directly or indirectly presents any conflict of interest with the pharmacy benefit manager's
882 relationship with or obligation to the carrier client.

883 (j) The division shall promulgate rules and regulations necessary for the implementation,
884 administration and enforcement of this chapter.

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

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

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

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

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

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

912 (iii) calling for an investigatory hearing with not less than 20 days' notice to the
913 pharmacy benefit manager for purposes of obtaining additional documentation, data, information
914 and testimony.

915 (e) Notwithstanding any general or special law to the contrary, including clause Twenty-
916 sixth of section 7 of chapter 4 and section 10 of chapter 66, the records of any such audit,
917 examination or other inspection and the information contained in the records, reports or books of
918 any pharmacy benefit manager examined pursuant to this section shall be confidential and open
919 only to the inspection of the commissioner, or the examiners and assistants. Access to such
920 confidential material may be granted by the commissioner to law enforcement officials of the
921 commonwealth or any other state or agency of the federal government at any time if the agency
922 or office receiving the information agrees in writing to keep such material confidential. Nothing
923 in this subsection shall be construed to prohibit the required production of such records, and
924 information contained in the reports of such company or organization before any court of the
925 commonwealth or any master or auditor appointed by any such court, in any criminal or civil
926 proceeding, affecting such pharmacy benefit manager, its officers, partners, directors or
927 employees. The final report of any such audit, examination or any other inspection by or on
928 behalf of the division of insurance shall be a public record.

929 Section 4. (a) A pharmacy benefit manager shall not make payments to a pharmacy
930 benefit consultant or broker whose services were obtained by a health benefit plan sponsor to
931 work on the pharmacy benefit bidding or contracting process if the payment constitutes a conflict
932 of interest, as determined by the commissioner. For purposes of this section, payments from a
933 pharmacy benefit manager to a pharmacy benefit consultant or broker shall include, but not be
934 limited to: (i) shared rebates from pharmaceutical manufacturers; (ii) per prescription fees; (iii)
935 per member fees; (iv) referral fees; (v) bonuses; or (vi) any other financial arrangement the
936 commissioner considers to be a conflict of interest.

937 (b) The division shall adopt any written policies or procedures or promulgate regulations
938 that the division determines are necessary to implement this section.

939 SECTION 38. The assessments in section 6 of chapter 6D of the General Laws, as
940 amended by section 5, and in section 7 of chapter 12C of the General Laws, as amended by
941 section 21, shall apply to the budgets for the health policy commission and the center for health
942 information and analysis, respectively, beginning in fiscal year 2026; provided, however, that
943 each pharmaceutical manufacturing company and each pharmacy benefit manager shall make a
944 preliminary payment to the commission on October 1, 2025 in an amount equal to 1/2 of the
945 initial year's total assessment, as determined by the commission and center, respectively, and
946 thereafter shall pay, within 30 days of receiving notice, the balance of the total assessment for the
947 initial year.

948 SECTION 39. Sections 26, 28, 31, 33, 34, and 35 shall apply to all contracts entered into,
949 renewed or amended on or after July 1, 2025.

950 SECTION 40. The commissioner of insurance shall promulgate regulations to implement
951 chapter 176Y of the General Laws not later than October 1, 2025.

952 SECTION 41. All pharmacy benefit managers operating within the commonwealth shall
953 be licensed in accordance with said chapter 176Y not later than January 1, 2026.