HOUSE DOCKET, NO. 1358 FILED ON: 1/14/2025

# HOUSE . . . . . No.

## The Commonwealth of Massachusetts

PRESENTED BY:

***John J. Lawn, Jr.***

*To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:*

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act relative to pharmacy benefit managers.

PETITION OF:

| NAME: | DISTRICT/ADDRESS: | DATE ADDED: |
|---|---|---|
| *John J. Lawn, Jr.* | *10th Middlesex* | *1/14/2025* |

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# HOUSE . . . . . No.

[Pin Slip]

## The Commonwealth of Massachusetts

**In the One Hundred and Ninety-Fourth General Court**
**(2025-2026)**

An Act relative to pharmacy benefit managers.

*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 176O of the General Laws is hereby amended by adding the following section:-

Section 31. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Cost-sharing", as defined in section 1 of chapter 176Y.

"Estimated rebate", any: (i) negotiated price concessions, whether described as a rebate or otherwise, including, but not limited to, base price concessions, and reasonable estimates of any price protection rebates and performance-based price concessions that may accrue, directly or indirectly, to a carrier, pharmacy benefit manager or other party on a carrier's behalf during a carrier's plan year from a pharmaceutical manufacturing company, dispensing pharmacy or other party to the transaction based on the amounts the carrier received in the prior quarter or reasonably expects to receive in the current quarter; and (ii) reasonable estimates of any price concessions, fees and other administrative costs that are passed through, or are reasonably

anticipated to be passed through to the carrier, pharmacy benefit manager or other party on the carrier's behalf and that serve to reduce the carrier's prescription drug liabilities for the plan year based on the amounts the carrier received in the prior quarter or reasonably expects to receive in the current quarter.

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

"Price protection rebate", a negotiated price concession that accrues directly or indirectly to the carrier, or other party on behalf of the carrier, including a pharmacy benefit manager, in the event of an increase in the wholesale acquisition cost of a drug that is greater than a specified threshold.

(b) A carrier, or any pharmacy benefit manager, shall make available to an insured at least 80 per cent of the estimated rebates received by such carrier, or any pharmacy benefit manager, by reducing the amount of defined cost-sharing that the carrier would otherwise charge at the point of sale, except that the reduction amount shall not result in a credit at the point of sale. Neither the insured nor the carrier shall be responsible for any difference between the estimated rebate amount and the actual rebate amount the carrier receives; provided, that such estimates were calculated in good faith.

(c) Nothing in this section shall preclude a pharmacy benefit manager from decreasing an insured's defined cost-sharing by an amount greater than that required under subsection (b).

(d) Annually, not later than April 1, a carrier shall file with the division a report in the manner and form determined by the commissioner demonstrating the manner in which the carrier has complied with this section. If the commissioner determines that a carrier has not complied with 1 or more requirements of this section, the commissioner shall notify the carrier of such

noncompliance and a date by which the carrier must demonstrate compliance. If the carrier does not come into compliance by such date, the division shall impose a fine not to exceed $5,000 for each day during which such noncompliance continues.

(e) In implementing the requirements of this section, the division shall only regulate a carrier or pharmacy benefit manager to the extent permissible under applicable law.

(f) A pharmacy benefit manager, its agent or any third-party administrator shall not publish or otherwise disclose information regarding the actual amount of rebates a carrier receives on a specific product or therapeutic class of products, manufacturer or pharmacy-specific basis. Such information shall be considered to be a trade secret and confidential commercial information, shall not be a public record as defined by clause Twenty-sixth of section 7 of chapter 4 or section 10 of chapter 66, and shall not be disclosed directly or indirectly, or in a manner that would allow for the identification of an individual product, therapeutic class of products or manufacturer, or in a manner that would have the potential to compromise the financial, competitive or proprietary nature of the information. A pharmacy benefit manager shall impose the confidentiality protections and requirements of this section on any agent or third-party administrator that performs health care or administrative services on behalf of the pharmacy benefit manager that may receive or have access to rebate related information.

SECTION 2. Section 1 of chapter 176Y of the General Laws, as most recently amended by section 37 of chapter 342 of the acts of 2024, is hereby amended by inserting after the definition of “Center” the following definition:-

"Clean claim", a claim that has no defect or impropriety, including a lack of any required substantiating documentation, or other circumstance requiring special treatment that prevents timely payment from being made on the claim.

SECTION 3. Said section 1 of said chapter 176Y, as most recently amended by said section 37 of said chapter 342 of the acts of 2024, is hereby further amended by inserting after the definition of "Commissioner" the following definition:-

"Cost-sharing", any copayment, coinsurance, deductible or any other amount owed by an insured under the terms of the insured's health benefit plan, or as required by a pharmacy benefit manager.

SECTION 4. Said section 1 of said chapter 176Y, as most recently amended by said section 37 of said chapter 342 of the acts of 2024, is hereby further amended by inserting after the definition of "Pharmacy benefit manager" the following 2 definitions:-

"Spread pricing", model of prescription drug pricing in which the pharmacy benefits manager charges a health benefit plan a contracted price for prescription drugs, and the contracted price for the prescription drugs differs from the amount the pharmacy benefits manager directly or indirectly pays the pharmacy.

"Third-party administrator", any person that directly or indirectly solicits or effects coverage of, underwrites, collects charges or premiums from, arranges alternative access to or funding for prescription drugs, or adjusts or settles claims on behalf of residents of the commonwealth or residents of another state from offices in this commonwealth, in connection with health insurance coverage.

SECTION 5. Said chapter 176Y, as most recently amended by said section 37 of said chapter 342 of the acts of 2024, is hereby further amended by inserting after section 4 the following 9 sections:-

Section 5. (a)(1) A pharmacy benefit manager shall have a duty to perform pharmacy benefit management services with care, skill, prudence, diligence and professionalism. Such duty shall extend to both the insured and the health plan for whom the pharmacy benefit manager is performing pharmacy benefit management services.

(2) A pharmacy benefit manager interacting with an insured shall have the same duty to an insured as the health plan for whom it is performing pharmacy benefit services.

(b) A pharmacy benefit manager shall have a duty of good faith and fair dealing with all parties with which it interacts in the performance of pharmacy benefit management services.

Section 6. (a) A pharmacy benefit manager shall provide a reasonably adequate and accessible pharmacy benefit manager network for the provision of prescription drugs, which shall provide for convenient patient access to pharmacies within a reasonable distance from a patient’s residence.

(b) A pharmacy benefit manager shall 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.

Section 7. (a) After adjudication 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 an aggregated effective rate, direct or indirect remuneration, quality assurance program or otherwise, except if the claim: (i) 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; or (ii) was submitted as a result of fraud, waste, abuse or other intentional misconduct.

(b) When a pharmacy adjudicates a claim, the reimbursement amount provided to the pharmacy by the pharmacy benefit manager shall constitute a final reimbursement amount; provided, however, that 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.

(c) No pharmacy benefit manager shall charge or collect from an insured any cost-sharing amount that exceeds the total contracted amount by the pharmacy for which the pharmacy is paid. If an insured pays a copayment, the pharmacy shall retain the adjudicated costs and the pharmacy benefit manager shall not reduce or recoup the adjudicated cost.

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

"Generically equivalent drug", a drug that is pharmaceutically and therapeutically equivalent to the drug prescribed.

“Maximum allowable cost list”, a listing of drugs or other methodology used by a pharmacy benefit manager, directly or indirectly, to set the maximum allowable payment to a pharmacy for a generic drug.

“National Drug Code”, the numerical code assigned to a prescription drug by the United States Food and Drug Administration.

“Pharmacy acquisition cost”, the net amount a pharmacy paid for a pharmaceutical product.

“Pharmacy benefit manager affiliate”, a pharmacy that directly or indirectly, through 1 or more intermediaries, owns or controls, is owned or controlled by or is under common ownership or control with a pharmacy benefits manager.

(b) A drug shall not be placed on a maximum allowable cost list unless:

(i) the drug is a generically equivalent drug, it is 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, it has an NR or NA rating by Medi-Span or Gold Standard, or it has a similar rating by a nationally recognized reference;

(ii) the drug is in stock and available for purchase by each pharmacy in the pharmacy benefit manager’s network from wholesale drug distributors licensed under section 36B of chapter 112; and

(iii) the drug is not obsolete.

(c) A pharmacy benefit manager shall:

(i) provide access to its maximum allowable cost list to each pharmacy in the pharmacy benefit manager's network that is subject to the maximum allowable cost list;

(ii) update its maximum allowable cost list on a timely basis, but not less than once every 7 calendar days;

(iii) 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

(iv) provide a reasonable internal grievance process consistent with subsection (d) to allow pharmacies to challenge a maximum allowable cost list as not compliant with this section, and to challenge reimbursements made under a maximum allowable cost list for a specific drug or drugs that are below the pharmacy acquisition cost.

(d)(1) A pharmacy benefit manager shall maintain a formal internal grievance process for pharmacies, in a form approved by the commissioner, and such formal internal grievance process shall provide for adequate consideration and timely resolution of grievances. A pharmacy benefit manager's internal grievance process shall include the following: (i) a dedicated telephone number, email address and website for the purpose of submitting a grievance; (ii) the ability to submit a grievance directly to the pharmacy benefit manager regarding the pharmacy benefits plan or program; and (iii) the ability to file a grievance within not less than 30 business days of the qualifying event.

(2) The pharmacy benefit manager shall respond to a grievance within 30 business days of receipt of the grievance. If the pharmacy benefit manager determines as a result of the internal grievance process that the pharmacy benefit manager's challenged conduct was not compliant with this section, the pharmacy benefit manager shall: (i) provide the pharmacy with the National

Drug Code upon which the maximum allowable cost was based; (ii) reprocess the claim; (iii) reimburse the pharmacy in an amount that is not less than the pharmacy acquisition cost; and (iv) to the extent practicable, reprocess claims submitted by similarly situated pharmacies and reimburse said pharmacies an amount that is not less than the pharmacy acquisition cost.

(3) If the pharmacy benefit manager determines as a result of the internal grievance process that the pharmacy benefit manager's challenged conduct was compliant with this section, the pharmacy benefit manager shall: (i) provide the pharmacy with the National Drug Code upon which the maximum allowable cost was based and the name of any wholesale drug distributors licensed under section 36B of chapter 112 that have the drug currently in stock at a price below the maximum allowable cost; or (ii) if the National Drug Code provided by the pharmacy benefit manager is not available at a price below the pharmacy acquisition cost from the wholesale drug distributor from whom the pharmacy purchases the majority of its 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 challenged maximum allowable cost.

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

(f) A violation of this section shall constitute an unfair or deceptive act or practice under chapter 93A.

Section 9. (a) No pharmacy benefit manager or carrier may, either directly or indirectly through an intermediary, agent or affiliate, engage in spread pricing. A pharmacy benefit manager or carrier that violates this section shall be subject to the surcharge under section 8.

(b) A pharmacy benefit manager shall report to the commissioner on a quarterly basis, for each health benefit plan with which it contracts, the data required to be collected by the center for health information and analysis pursuant to section 10A of chapter 12C.

Section 10. (a) A pharmacy benefit manager or carrier shall be subject to a surcharge payable to the division equal to 10 per cent of the aggregate dollar amount of reimbursements paid by the pharmacy benefit manager or carrier to pharmacies in the previous contract year for prescription drugs in the commonwealth if the pharmacy benefit manager or carrier: (i) engages in spread pricing; or (ii) imposes point-of-sale fees or retroactive fees. A carrier shall be jointly responsible to pay the surcharge amount for violations of this section by its contracted pharmacy benefit manager; provided, however, that a carrier shall not be jointly responsible to pay the surcharge amount for violations of this section by its contracted pharmacy benefit manager unless the contract between the carrier and the pharmacy benefit manager permits conduct prohibited by this section.

(b) A pharmacy benefit manager or carrier subject to enforcement action by the division for a violation of this section shall, upon the filing of a written request with the division, be afforded an adjudicatory hearing pursuant to chapter 30A.

Section 11. (a) When calculating an insured’s contribution to any applicable cost-sharing requirement, a carrier shall include any cost-sharing amounts paid by the insured or on behalf of the insured by another person. If under federal law, application of this requirement would result

in health savings account ineligibility under section 223 of the federal Internal Revenue Code, this requirement shall apply for health savings account-qualified high deductible health plans with respect to the deductible of such a plan after the insured has satisfied the minimum deductible under section 223 of the federal Internal Revenue Code, except for with respect to items or services that are preventive care pursuant to section 223(c)(2)(C) of the federal Internal Revenue Code, in which case the requirements of this paragraph shall apply regardless of whether the minimum deductible under section 223 has been satisfied.

(b) A carrier, pharmacy benefit manager or third-party administrator shall not directly or indirectly set, alter, implement or condition the terms of health benefit plan coverage, including the benefit design, based in part or entirely on information about the availability or amount of financial or product assistance available for a prescription drug.

(c) The division may promulgate such rules and regulations as it may deem necessary to implement this section.

Section 12. 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 13. (a) A contract between a pharmacy benefit manager and a pharmacy shall not include any provision that prohibits, restricts or limits a pharmacy or its employed pharmacists' ability to provide an insured with information on the amount of the insured's cost-sharing for such insured's prescription drug and the clinical efficacy of a more affordable alternative drug if one is available. No contract shall penalize a pharmacy or an individual pharmacist for disclosing

such information to an insured or for dispensing to an insured a more affordable alternative prescription drug if one is available.

(b) A pharmacy benefit manager shall not charge a pharmacy a fee related to the adjudication of a claim unless such fee is set out in a contract between the pharmacy benefit manager and the pharmacist or contracting agent or pharmacy, including, but not limited to, 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.

(c) A contract between a pharmacy benefit manager and a pharmacy 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.