HOUSE DOCKET, NO. 2354 FILED ON: 1/16/2025

HOUSE . . . . . No.

The Commonwealth of Massachusetts

PRESENTED BY:

Alan Silvia

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 prescription drug pricing.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
Alan Silvia	*7th Bristol*	*1/16/2025*

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HOUSE . . . . . No.

[Pin Slip]

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE HOUSE, NO. *1148* OF 2023-2024.]

The Commonwealth of Massachusetts

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

An Act relative to prescription drug pricing.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

Chapter 175 of the General Laws is hereby amended by inserting after section 226 the following section:-

Section 226A. (a) The following terms, as used in this section, shall, unless the context requires otherwise, have the following meanings:—

"Commissioner", the commissioner of insurance.

"Covered entity", a nonprofit hospital or medical service organization, insurer, health coverage plan or health maintenance organization; a health program administered by the commonwealth in the capacity of provider of health coverage; or an employer, labor union, or other entity organized in the state that provides health coverage to covered individuals who are employed or reside in the state. This term does not include a health plan that provides coverage

only for accidental injury, specified disease, hospital indemnity, disability income, or other limited benefit health insurance policies and contracts that do not include prescription drug coverage.

"Covered individual", a member, participant, enrollee, contract holder or policy holder or beneficiary of a covered entity who is provided health coverage by the covered entity. A covered individual includes any dependent or other person provided health coverage through a policy, contract or plan for a covered individual.

"Maximum allowable cost" or "MAC", the list of drug products delineating the maximum per-unit reimbursement for multiple-source prescription drugs, medical product or device.

"Multisource drug product reimbursement", the total amount paid to a pharmacy inclusive of any reduction in payment to the pharmacy, excluding prescription dispense fees.

"Pharmacy benefits management", a service provided to covered entities to facilitate the provision of prescription drug benefits to covered individuals within the state, including negotiating pricing and other terms with drug manufacturers and providers. Pharmacy benefits management may include any or all of the following services:

a. claims processing, retail network management and payment of claims to pharmacies for prescription drugs dispensed to covered individuals,

b. clinical formulary development and management services,

c. rebate contracting and administration,

d. certain patient compliance, therapeutic intervention and generic substitution programs, or

e. disease management programs;

"Pharmacy benefits manager" or "PBM", a person, business or other entity that performs pharmacy benefits management. The term includes a person or entity acting for a PBM in a contractual or employment relationship in the performance of pharmacy benefits management for a managed care company, nonprofit hospital, medical service organization, insurance company, third-party payor, or a health program administered by an agency of this state;

"Plan sponsor", the employers, insurance companies, unions and health maintenance organizations or any other entity responsible for establishing, maintaining, or administering a health benefit plan on behalf of covered individuals; and

"Provider", a pharmacy licensed by the board of registration in pharmacy, or an agent or representative of a pharmacy, including, but not limited to, the pharmacy's contracting agent, which dispenses prescription drugs or devices to covered individuals.

(b) In order to provide pharmacy benefits management or any of the services included under the definition of pharmacy benefits management in the commonwealth, a pharmacy benefits manager or any entity acting as one in a contractual or employment relationship for a covered entity shall first obtain a license from the commissioner, and the commissioner may charge a fee for such licensure.

(c) The commissioner shall establish, by regulation, licensure procedures, required disclosures for pharmacy benefits managers and other rules as may be necessary for carrying out and enforcing the provisions of this section. The licensure procedures shall, at a minimum, include the completion of an application form that shall include the name and address of an agent for service of process, the payment of a requisite fee, and evidence of the procurement of a surety bond.

(d) The commissioner may subpoena witnesses and information and may take and copy records for investigative use and prosecutions. Nothing in this subsection shall limit the attorney general from using its investigative demand authority to investigate and prosecute violations of the law.

(e) The commissioner may suspend, revoke or refuse to issue or renew a license for noncompliance with any of the provisions hereby established or with the rules promulgated by the commissioner; for conduct likely to mislead, deceive or defraud the public or the commissioner; for unfair or deceptive business practices or for nonpayment of a renewal fee or fine. The commissioner may also levy administrative fines for each count of which a PBM has been convicted in a hearing.

(f) A pharmacy benefits manager shall provide, upon request by the covered entity, information regarding the difference in the amount paid to providers for prescription services

rendered to covered individuals and the amount billed by the pharmacy benefits manager to the covered entity or plan sponsor to pay for prescription services rendered to covered individuals.

(g) The pharmacy benefits manager shall, with respect to contracts between a pharmacy benefits manager and a provider, including a pharmacy service administrative organization:

1. Include in such contracts the specific sources utilized to determine the maximum allowable cost pricing of the pharmacy, update MAC pricing at least every 7 calendar days, and establish a process for providers to readily access the MAC list specific to that provider;

2. In order to place a drug on the MAC list, ensure that the drug is listed as "A" or "B" rated in the most recent version of the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, and the drug is generally available for purchase by pharmacies in the state from national or regional wholesalers and is not obsolete;

3. Ensure dispensing fees are not included in the calculation of MAC price reimbursement to pharmacy providers;

4. Provide a reasonable administration appeals procedure to allow a provider, a provider's representative and a pharmacy service administrative organization to contest reimbursement amounts within 14 business days of the final adjusted payment date. The pharmacy benefits manager shall not prevent the pharmacy or the pharmacy service administrative organization from filing reimbursement appeals in an electronic batch format. The pharmacy benefits manager must respond to a provider, a provider's representative and a pharmacy service administrative organization who have contested a reimbursement amount through this procedure within 10

business days. The pharmacy benefits manager must respond in an electronic batch format to reimbursement appeals filed in an electronic batch format. The pharmacy benefits manager shall not require a pharmacy or pharmacy services administrative organization to log into a system to upload individual claim appeals or to download individual appeal responses. If a price update is warranted, the pharmacy benefits manager shall make the change in the reimbursement amount, permit the dispensing pharmacy to reverse and rebill the claim in question, and make the reimbursement amount change retroactive and effective for all contracted providers; and

5. If a below-cost reimbursement appeal is denied, the PBM shall provide the reason for the denial, including the National Drug Code number from the specific national or regional wholesalers where the drug is available for purchase by the dispensing pharmacy at a price below the PBM's reimbursement price. If the pharmacy benefits manager cannot provide a specific national or regional wholesaler where the drug can be purchased by the dispensing pharmacy at a price below the pharmacy benefits manager's reimbursement price, the pharmacy benefits manager shall immediately adjust the reimbursement amount, permit the dispensing pharmacy to reverse and rebill the claim in question, and make the reimbursement amount adjustment retroactive and effective for all contracted providers.

(h) The pharmacy benefits manager shall not place a drug on a MAC list, unless there are at least 2 therapeutically equivalent, multiple-source drugs, generally available for purchase by dispensing retail pharmacies from national or regional wholesalers.

(i) The pharmacy benefits manager shall not require accreditation or licensing of providers, or any entity licensed or regulated by the board of registration in pharmacy, other than

by the board of registration in pharmacy or federal government entity as a condition for participation as a network provider.

(j) A pharmacy or pharmacist may decline to provide the pharmacist clinical or dispensing services to a patient or pharmacy benefits manager if the pharmacy or pharmacist is to be paid less than the pharmacy's cost for providing the pharmacist clinical or dispensing services.

(k) The pharmacy benefits manager shall provide a dedicated telephone number, email address and names of the personnel with decision-making authority regarding MAC appeals and pricing.