MTF Massachusetts Taxpayers Foundation

Bill Order	Bill Section	MGL Chapter	MGL Section	Bill Section Summary
1	Sections 1 and 2	6D	1	Adds definitions of "Generic drug", "Pharmaceutical Manufacturing Company", and "Pharmacy Benefit Manager" to HPC statute
2	3	6D	***3A***	Creates a new Office for Pharmaceutical Policy and Analysis within the HPC. The Office shall • Analyze drug spending trends and other information collected by the HPC and other agencies, produce reports, ID proposed supplemental rebates for eligible drugs, and advise the legislature. • Analyses shall include an annual survey of payers on drug access, plan design, and member costs. • The Office will produce an annual report (due 9/1) on drug trends as they relate to costs, drugs with the highest impact on costs, patient drug spending, and access & affordability for patients with rare and chronic diseases or drugs designated as "first in class". • The office is directed to consult with the Rare Disease Advisory Council on drugs related to rare diseases or designated as "first in class" by the FDA. • In working with the Commission to ID proposed supplemental rebates, the Office will consider effectiveness, patient quality of life, and likely impact on the need for future medical care.
3	4	6D	4	Adds representatives of PBMs to the HPC advisory council
4	5	6D	6	Adds non-hospital provider organizations (between 3 and 8 percent), pharmaceutical manufacturers (between 5 and 10 percent), and pharmacy benefit managers (between 5 and 10 percent) to the list of entities assessed to support the operations of the HPC. The assessment on PMs and PBMs is contingent on the assessment not resulting in any reduction in federal Medicaid reimbursement. Non-hospital provider organizations include clinical labs, image facilities, and urgent care centers or non-hospital-based physician practices with at least $500M in annual gross patient service revenue. The assessment on acute hospitals, ambulatory surgical centers, and non-hospital provider organizations will be between 30 and 40 percent.
5	6 through 11	6D	8	Makes several changes to MGL 6D:8 (Health Care Cost Trends Hearing). The changes: • Add to the scope of healthcare entities under the purview of the hearings to include PMs, PBMs, and relevant impact of significant equity investors, HC REITs, and MSOs on cost, price, and cost trends • Add significant equity investors, HC REITS, and management services organizations to the list of required participants • Add 3 drug manufacturers (one publicly traded, one generic, one in business less than 10 years) and 2 PBMs to the list of required participators • Adds ED of the Health Connector and EOHHS Assistant Secretary for MassHealth to the list of required participants and directs HPC to ask CMS to participate • Define the scope of testimony for the MassHealth director, significant equity investors, and pharmaceutical participants • Update language governing the cost trend report to reflect the expanded scope of the hearing • Require the HPC report to include recommendations to increase the efficiency and affordability of health care
6	12 & 13	6D	9	Adds pharmaceutical manufacturing/PBM information to the list of things examined at the HPC hearing to modify the state's health cost growth benchmark and to the list of witnesses for the health care cost trends hearing.
7	14	6D	23	Directs HPC, in conjunction with CHIA, GIC, and MassHealth to conduct an evaluation of the co-payment caps established in the bill. The evaluation will be conducted every two years and will consider impacts on premiums, drug spending, rebates, cost-sharing, utilization, and health impacts.

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8	15 & 16	12C	1	Adds following definitions to CHIA statute: • Payer • Pharmaceutical manufacturing company • Pharmacy benefit manager (PBM • Wholesale acquisition cost (WAC)
9	17	12C	3	Adds pharmaceutical manufacturers/PBMs to the list of organizations which CHIA is to collect, analyze, and disseminate data.
10	18	12C	3	Adds pharmaceutical manufacturers/PBMs cost information to the list of things about which CHIA is to provide information at annual HPC cost trend hearings.
11	19	12C	5	Adds pharmaceutical manufacturers/PBMs to the list of organizations to be consulted on CHIA regulatory changes.
12	20	12C	5	Adds pharmaceutical manufacturers/PBMs to the list of organizations to be consulted on CHIA reporting requirements.
13	21	12C	7	Updates the CHIA assessment to: • Require pharmaceutical manufacturing companies, PBMs, and non-hospital provider organizations to be assessed for CHIA costs • Changing the provider and carrier share of the CHIA assessment from not less than 33% to between 30 and 40% • Assessing non-hospital provider organizations between 3 and 8% of the CHIA assessment • Assessing pharmaceutical manufacturing companies and PBMs between 5 and 10% of the CHIA assessment, provided that it does not reduce the amount of FFP to MassHealth • Drug company payments shall be made based on MassHealth's spending on the company's drugs, and PBM payments shall be made based on each PBM's share of total claims paid attributed to residents of the Commonwealth.
14	22	12C	10A	Creates a new section directing CHIA to create a uniform data reporting system for PBMs. The new system will allow analysis of: • Year-over-year WAC changes • Year-over-year trends in formulary, max allowable cost lists and cost share design • Aggregate info on discounts, utilization limits, rebates, fees, etc. • Trends in drug rebates and drug price reductions provided to PBM clients as well as a measure of lives covered • Data necessary for DOI oversight of PBMs In order to analyze this information, CHIA can require the collection of PBM data on rebates (including amounts retained by the PBM and amounts passed through to clients), fees, information on contract design, spread pricing, claw backs, and formulary placement. Data collected shall not be a public record and no data shall be disclosed in a manner likely to compromise the financial, proprietary nature of the information or enable identification of specific prices charged for drugs, the value of rebate amounts, or information on individual drugs or pharmaceutical manufacturing companies.
15	23	12C	11	Adds PBMs to the list of entities for whom CHIA is empowered to required timely data collection.

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16	24	12C	12	Included PBM data reporting section in provision defining CHIAs powers and responsibilities for collecting data.
17	25	12C	16	Adds information on pharmaceutical manufacturers and PBM to the scope of the CHIA annual report.
18	26	32A	17Z	Creates a co-pay capping program within CHIA. Under the program: • GIC is annually required to ID (and make public) one generic and one brand name drug used to treat diabetes (which must include insulin), asthma, and the 2 most prevalent heart conditions among its members • In ID'ing drugs, GIC is to consider factors including the benefit of the drug, likelihood to reduce future treatment, utilization, risk of over-utilization, and cost-effectiveness • ID'd generic drugs shall be provided without cost-sharing requirements including co-pay and co-insurance. ID'd drugs shall not be subject to a deductible. • ID'd brand name drugs shall have co-pays capped at $25 for a 30-day supply and will also not be subject to a deductible or co-insurance • GIC shall provide continuity of coverage by providing a 30-day fill for new members on an FDA-approved drug that the member has already been prescribed as part of a stable course of treatment. Continuity of coverage will not be subject to any greater deductible, co-insurance, or copay than any other benefit.
19	27	94C	21C	Requires pharmacies to charge individuals the lesser of the applicable cost-sharing amount and the retail cost of the drug and prohibits insurers from requiring a cost-sharing payment for a drug that is greater than the lesser of the cost-sharing amount or the retail price of the drug.
20	28	118E	10Z	Creates a co-pay capping program within MassHealth. Under the program: • MassHealth is annually required to ID (and make public) one generic and one brand name drug used to treat diabetes (which must include insulin), asthma, and the 2 most prevalent heart conditions among its members • In ID'ing drugs, MassHealth is to consider factors including the benefit of the drug, likelihood to reduce future treatment, utilization, risk of over-utilization, and cost-effectiveness • ID'd generic drugs shall be provided without cost-sharing requirements including co-pay and co-insurance. ID'd drugs shall not be subject to a deductible. • ID'd brand name drugs shall have co-pays capped at $25 for a 30-day supply and will also not be subject to a deductible or co-insurance • This cost-capping policy does not apply to Senior Care Option plans. • MassHealth shall provide continuity of coverage by providing a 30-day fill for new members on an FDA-approved drug that the member has already been prescribed as part of a stable course of treatment. Continuity of coverage will not be subject to any greater deductible, co-insurance, or copay than any other benefit.
21	Sections 29 & 30	118E	64	Updates definitions of CHIA and HPC revenue amounts to account for new expanded assessment group.

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22	31	175	***47CCC***	Creates a co-pay capping program for carriers subject to MGL 175. Under the program: • Affected insurers are annually required to ID (and make public) one generic and one brand name drug used to treat diabetes (which must include insulin), asthma, and the 2 most prevalent heart conditions among its members • In ID'ing drugs, insurers are to consider factors including the benefit of the drug, likelihood to reduce future treatment, utilization, risk of over-utilization, and cost-effectiveness • ID'd generic drugs shall be provided without cost-sharing requirements including co-pay and co-insurance. ID'd drugs shall not be subject to a deductible. • ID'd brand name drugs shall have a co-pay capped at $25 for a 30-day supply and will also not be subject to a deductible or co-insurance • Any policy qualifying as providing credible coverage shall provide continuity of coverage by providing a 30-day fill for new members on an FDA-approved drug that the member has already been prescribed as part of a stable course of treatment. Continuity of coverage will not be subject to any greater deductible, co-insurance, or copay than any other benefit.
23	32	175	226	Requires DOI to promulgate regulations related to auditing of pharmacies (currently may)
24	33	176	***8DDD***	Creates a co-pay capping program for carriers subject to MGL 176A. Under the program: • Affected insurers are annually required to ID (and make public) one generic and one brand name drug used to treat diabetes (which must include insulin), asthma, and the 2 most prevalent heart conditions among its members • In ID'ing drugs, insurers are to consider factors including the benefit of the drug, likelihood to reduce future treatment, utilization, risk of over-utilization, and cost-effectiveness • ID'd generic drugs shall be provided without cost-sharing requirements including co-pay and co-insurance. ID'd drugs shall not be subject to a deductible. • ID'd brand name drugs shall have co-pay capped at $25 for a 30-day supply and will also not be subject to a deductible or co-insurance • Any affected health benefit shall provide continuity of coverage by providing a 30-day fill for new members on an FDA-approved drug that the member has already been prescribed as part of a stable course of treatment. Continuity of coverage will not be subject to any greater deductible, co-insurance, or copay than any other benefit.
25	34	176B	4DDD	Creates a co-pay capping program for carriers subject to MGL 176B. Under the program: • Affected insurers are annually required to ID (and make public) one generic and one brand name drug used to treat diabetes (which must include insulin), asthma, and the 2 most prevalent heart conditions among its members • In ID'ing drugs, insurers are to consider factors including the benefit of the drug, likelihood to reduce future treatment, utilization, risk of over-utilization, and cost-effectiveness • ID'd generic drugs shall be provided without cost-sharing requirements including co-pay and co-insurance. ID'd drugs shall not be subject to a deductible. • ID'd brand name drugs shall have co-pay capped at $25 for a 30-day supply and will also not be subject to a deductible or co-insurance • Any affected health benefit shall provide continuity of coverage by providing a 30-day fill for new members on an FDA-approved drug that the member has already been prescribed as part of a stable course of treatment. Continuity of coverage will not be subject to any greater deductible, co-insurance, or co-pay than any other benefit.

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26	35	176G	4VV	Creates a co-pay capping program for carriers subject to MGL 176G. Under the program: • Affected insurers are annually required to ID (and make public) one generic and one brand name drug used to treat diabetes (which must include insulin), asthma, and the 2 most prevalent heart conditions among its members • In ID'ing drugs, insurers are to consider factors including the benefit of the drug, likelihood to reduce future treatment, utilization, risk of over-utilization, and cost-effectiveness • ID'd generic drugs shall be provided without cost-sharing requirements including co-pay and co-insurance. ID'd drugs shall not be subject to a deductible. • ID'd brand name drugs shall have co-pay capped at $25 for a 30-day supply and will also not be subject to a deductible or co-insurance • Any affected health benefit shall provide continuity of coverage by providing a 30-day fill for new members on an FDA-approved drug that the member has already been prescribed as part of a stable course of treatment. Continuity of coverage will not be subject to any greater deductible, co-insurance, or copay than any other benefit.
27	36	1760	30 (NEW)	Requires insurers to annually report to DOI the drugs selected for the cost-capping program created in the bill. DOI will review the drugs selected to ensure that they comply with the requirements of the policy. If there is a lack of compliance, DOI can require the selection of another drug. DOI will publish the list of selected drugs annually on its website.
28	37	176Y (New)	1	Creates a new MGL chapter regulating PBMs. Section 1 defines terms relevant to the chapter: • Carrier • Commissioner of Insurance • Division of Insurance • Health benefit plan • Insured • Mail-order pharmacy • Pharmacy • Pharmacy benefit management services • Pharmacy benefit manager
29	37	176Y (New)	2	Prohibits a PBM from operating without receiving a license from DOI. Further defines the process for PBM licensure: • Prohibits transfer of PBM licenses • Requires PBMs to comply with CHIA data collection requirements • Empowers DOI to suspend, revoke, or refuse a license for cause or to put restrictions on licenses; the section also sets forth situations in which DOI can suspend, revoke, or refuse a license with written notice and an opportunity for a hearing • Requires DOI to develop a PBM licensure application • Requires PBMs to notify DOI of potential conflicts of interest with obligations to a carrier client • Sets forth penalties for violating the section

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30	37	176Y (New)	3	Defines the process for examinations of PBMs: • Commissioner of DOI to examine PBMs at least once every 3 years; the examination may be on-site • Examiner in charge shall file a report on the examinations within 60 days • PBM has 30 days to respond or rebut any aspects of the examination • DOI can order the PBM to take action to address any identified violations • DOI can accept the report, demand a reopening of the examination, or call for an investigatory hearing • Records of audits are confidential, though can be shared with other state and federal agencies (provided they keep the information confidential) • The final report of any audit will be a public record
31	37	176Y (New)	4	Prohibits PBMs from making payments to a pharmacy benefit consultant or broker whose services were obtained by a health benefit plan sponsor to work on the pharmacy benefit bidding or contracting process if the payment constitutes a conflict of interest as determined by DOI. The section enumerates the types of payments governed by the section.
32	38	NWS		Makes new assessment structure of HPC and CHIA effective for FY 2026.
33	39	NWS		Makes co-pay capping program effective for insurance contracts entered into, renewed, or amended on or after 7/1/2025.
34	40	NWS		Directs DOI to promulgate PBM regulations by 10/1/2025
35	41	NWS		Requires all PBMs in Massachusetts to be licensed by 1/1/2026