State PBM Reform Inventory

Updated October 2026

Massachusetts

Issue	Summary	Citation
Licensing/Registration	PBMs must obtain a license from the Division of Insurance. A license may be granted only when the division is satisfied that the entity possesses the necessary organization, background, expertise, and financial integrity to supply the services sought to be offered. A PBM license shall be valid for a period of 3 years and shall be renewable for additional 3-year periods. The commissioner shall charge application and renewal fees of $25,000.	M.G.L. c. 176Y § 2
Reporting Requirements	The Center for Health Information and Analysis (CHAI) shall promulgate regulations necessary to ensure the uniform reporting of information from PBMs to enable the center to analyze: • Year-over-year changes in WAC; • Year-over-year trends in formulary, MAC lists and cost-sharing design, including the establishment and management of specialty product lists; • Aggregate information regarding discounts, utilization limits, rebates, administrative fees charged to pharmaceutical manufacturing companies and other financial incentives or concessions related to pharmaceutical products or formulary programs; • Trends in estimated aggregate drug rebates and other aggregate drug price reductions, if any, provided by a PBM to a carrier client or health plan sponsor or passed through from a PBM to a carrier client or health plan sponsor in connection with utilization of drugs in the commonwealth offered through the PBM and a measure of lives covered by each carrier client or health plan sponsor in the commonwealth; and • Any other information deemed reasonably necessary by the center by regulation. CHAI shall require the submission of available data and other information from PBMs including, but not limited to:	M.G.L. c. 12C § 10A; M.G.L. c. 176Y § 2; M.G.L. c. 176Y § 3

	• The aggregate amount of all rebates that the PBM received from all pharmaceutical manufacturing companies and for all carrier clients or health plan sponsors; • The administrative fees that the PBM received from all carrier clients or health plan sponsors in the aggregate and for each carrier client or health plan sponsor individually; • The aggregate amount of rebates a PBM: (A) retains based on its contractual arrangement with each carrier client or health plan sponsor individually; and (B) passes through to each carrier client or health plan sponsor individually; • The aggregate amount of all retained rebates that the PBM received from all pharmaceutical manufacturing companies and did not pass through to each PBM's carrier client or health plan sponsor individually; • The percentage of contracts that a PBM holds where the PBM: (A) retains all rebates; (B) passes all rebates through to the carrier client or health plan sponsor; and (C) shares rebates with the carrier client or health plan sponsor; and • Information related to the PBM practices of spread pricing, administrative fees, claw-backs, and formulary placement. A licensed PBM shall submit data and reporting information to CHAI. The commissioner may examine the affairs of a PBM when the commissioner deems it prudent, but not less frequently than once every 3 years. The focus of the examination shall be to ensure that a PBM can meet its responsibilities under contracts with carriers. The examination shall be conducted according to the procedures set forth in paragraph (6) of section 4 of chapter 175. If the examination report reveals that the PBM is operating in violation of this section or any regulation or prior order of the commissioner, the commissioner may order the PBM to take any action the commissioner considers necessary and appropriate to cure such violation.	

	Any carrier, including a PBM, that provides administrative services to 1 or more self-insured groups shall submit to the division a report including the following information by April 1: • The number of the carrier's self-insured customers; • The aggregate number of members, as defined in section 1 of chapter 176J, in all of the carrier's self-insured customers; • The aggregate number of lives covered in all of the carrier's self-insured customers; • The percentage of the carrier's self-insured customers that include each of the benefits mandated for health benefit plans under chapters 175, 176A, 176B and 176G; and • Any other information deemed necessary by the commissioner.	
PBM Income	N/A	
Pharmacy Contracting	N/A	
Patient Cost-Sharing	**Copay Cap:** Any policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within the commonwealth and which is considered creditable coverage under section 1 of chapter 111M shall identify 1 generic drug and 1 brand name drug used to treat each of the following chronic conditions: (i) diabetes; (ii) asthma; and (iii) the 2 most prevalent heart conditions among its enrollees. The carrier shall identify insulin as the drug used to treat diabetes. In determining the 1 generic drug and 1 brand name drug used to treat each chronic condition, the carrier shall consider whether the drug is: • of clear benefit and strongly supported by clinical evidence; • likely to: (A) reduce hospitalizations or emergency department visits; (B) reduce future exacerbations of illness progression; or (C) improve quality of life; • cost effective for the carrier and its enrollees; • at low risk for overutilization, abuse, addiction, diversion or fraud; and • one of the most widely utilized as a treatment for the chronic condition. Applicable carriers shall provide coverage for the brand-name drugs and generic drugs identified via the process described	M.G.L. c. 175 § 47CCC; M.G.L. c. 118E § 10Z; M.G.L. c. 94C § 21C

	above. Coverage for the identified generic drugs shall not be subject to cost- sharing, including co-payments and co-insurance, and shall not be subject to any deductible; provided, however, that cost-sharing shall be required if the applicable plan is governed by the Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on cost-sharing under this section. Coverage for identified brand-name drugs shall not be subject to any deductible or co- insurance, and any co-payment shall not exceed $25 per 30-day supply. Coverage for 1 brand-name insulin drug per dosage and type, including rapid-acting, short-acting, intermediate-acting, long-acting, ultra long-acting, and premixed under this section shall not be subject to any deductible or co-insurance, and any co-payment shall not exceed $25 per 30-day supply. The carrier may make changes in its selection of drugs pursuant to this section not more than annually. The carrier shall make public the identified drugs for each applicable chronic condition. Similar requirements apply to MassHealth (Medicaid), plans sold on the individual marketplace, and state employee benefit plans. **Maximum Cost-Sharing Levels:** At the point of sale, a pharmacy shall charge an individual for a prescription drug the lesser of: (i) the applicable cost-sharing amount; or (ii) the pharmacy retail price. A health benefit plan or carrier shall not require an insured to make a cost-sharing payment for a prescription drug in an amount greater than that charged by a pharmacy complying with this section.	