MAHP
MASSACHUSETTS ASSOCIATION of HEALTH PLANS

June 10, 2025

Senator Paul Feeney, Chair
Joint Committee on Financial Services
State House, Room 112
Boston, MA 02133

Representative James Murphy, Chair
Joint Committee on Financial Services
State House, Room 254
Boston, MA 02133

RE: 6/10 Joint Committee on Financial Services Legislative Hearing
MAHP Opposition: House Nos. 1082, 1125, 1133, 1155, 1157, 1222, 1234, 1274, 1305, 1322, 1324, 1325, 1330, 1364 and 4043 and Senate Nos. 687, 693, 694, 724, 734, 777, 781, 830, and 831
MAHP Support: House No. 1092

Dear Chairs Feeney and Murphy,

On behalf of the Massachusetts Association of Health Plans and our 13 member health plans and one behavioral health organization, providing health insurance coverage to nearly 3 million Massachusetts residents, we appreciate the opportunity to share feedback on the following bills before your committee that will raise costs for small businesses and their employees. Health care affordability is the number one challenge facing individuals and small businesses in this state, driven by ever-increasing prices for prescription drugs, hospitals and providers. Without action to address the key cost drivers, the Commonwealth cannot make health care more affordable.

Pharmaceutical spending is the largest driver of health care costs in Massachusetts, as identified by the Health Policy Commission (HPC) and the Center for Health Information and Analysis (CHIA). And because premiums directly reflect the cost of care, increases in drug prices—especially for brand-name and specialty drugs—are passed on to consumers, despite insurers' efforts to manage utilization and encourage cost-effective prescribing. As in prior years, the increase in prescription drug spending is driven by branded drugs, which comprise only 15% of commercial pharmacy volume, but account for the majority of prescription drug spending on a gross basis (roughly 80%). These factors have led to a 68.9% growth in average gross spending per branded prescription from 2017 to 2022, with the prices of over 5% of prescriptions filled in 2022 exceeding $6,309.

Massachusetts health plans are highly regulated, spending 88% of every premium dollar on medical care. When drug costs spike, so do premiums—jeopardizing affordability and access. One only needs to look to MassHealth and GIC to understand the pressure that the commercial plans are under. Given that health care prices in Massachusetts continue to exceed the state's health care cost benchmark, it is imperative that we take meaningful action to make health care coverage more affordable.

Health plans have limited tools to direct members to safe, effective, and lower cost drugs and the pharmaceutical industry is focused on removing these tools to drive members to new, marketed, high cost drugs, when in fact, there are lower cost drugs on the market today that may be equally as effective. We discuss our opposition to these bills below.

Oppose:

House No. 1234, An Act relative to pharmacy benefit managers; House No. 1325, An Act to ensure access to generic medication; and House No. 1364 / Senate No. 724, An Act promoting healthcare access and affordability for patients – Oppose

H1234, H325, H1364, and S724 impose new requirements on pharmacy benefit managers (PBMs), on the contracts between PBMs and health plans, and on certain practices PBMs employ to reduce pharmacy costs for health plan members, including imposing restrictions on the use of maximum allowable cost (MAC) benchmarks for generic drugs that will impact the ability to secure fair reimbursement to pharmacies for generic drugs. Each of these proposals will increase costs for individuals, employers, and small businesses.

Health plans contract with PBMs to administer pharmacy benefits due to PBMs' expertise and capacity to administer pharmacy benefits in a cost-effective and efficient manner. PBMs negotiate directly with drug manufacturers and leverage scale to lower health care costs, due to their ability to leverage the covered lives of all their health plan clients. Individual health plans acting alone can only leverage their own membership to counter the pricing power of drug manufacturers. PBM-negotiated rebates and formulary tools help reduce costs for employers, unions, Medicaid programs, and consumers. Health plans use these tools to hold down premiums and out-of-pocket costs, and to encourage the use of more affordable, equally effective alternatives. When operating in alignment with health plans, PBMs help to achieving affordability in the face of an industry that is increasingly launching drugs at prices well into six figures. As we've seen with gene therapies and new GLP-1 drugs, the list prices are set unilaterally by the manufacturer, and PBMs are one of the few tools available to counterbalance that power.

While MAHP and our member health plans see value in the role that PBMs play in containing rising health care costs, health care cost containment is a shared responsibility among all players in the health care sector. Therefore, we supported the pharmacy legislation enacted last session, Chapter 342 of the Acts of 2024, that contained important reforms to transparency around how drug prices are set and to understand the role that PBMs play and established a new PBM licensure requirement at the DOI.

However, these bills would significantly diminish the ability of health plans to ensure access to safe, effective, and affordable prescription drugs. Health plans have limited tools to direct members to safe, effective, and lower cost drugs. While improving transparency around PBMs is important, it is critical that the state continue to look at the full picture and not lose sight that the primary factor behind rising drug costs are the high launch prices and yearly increase -often without any corresponding clinical innovation.

H1234, H1364, and S724 impose a "point-of-sale rebate" requirement on health plans and PBMs. Such a mandate requires the health plan and PBM to pass-through 80% of the estimated rebate for a prescription drug to the member at the point of sale. While point-of-sale rebates are described as a way to reduce out-of-pocket spending for certain members that use expensive brand medications, the reality is that the proposal will increase premiums for employers and their employees. Rebates are a tool aimed at offsetting the exorbitant cost of prescription drugs and reducing the impact on purchasers of health care. Rebates are then spread across a health plan's entire membership to reduce members' out-of-pocket costs and lower the cost of care. If rebate dollars are required to be paid at the point of sale, as an offset to cost sharing, health plans would need to raise premiums to make up for the difference. Point-of-sale rebates would be exceedingly costly and administratively challenging to implement because rebates are not calculated on a per member basis. **A nation-wide study estimated that point-of-sale rebate laws in every state could increase drug spending in the commercial market by tens of millions of dollars annually and an estimated $71.1 billion nationally over 10 years and $1.673 billion over 10 years in Massachusetts.**

H1234 and H1325 include excessive restrictions on PBM programs designed to use maximum allowable cost (MAC) benchmarks to ensure a fair reimbursement to pharmacies for generic drugs, including a mandate to release proprietary pricing lists; allowing pharmacies to appeal a MAC price thereby mandating

health plans or PBMs pay specific levels of reimbursement to guarantee pharmacy profits. Each manufacturer has its own price for a particular generic drug, and these prices can differ extensively by manufacturer. MAC lists are the maximum allowable reimbursement that a PBM or health plan will pay for a particular generic drug. Payers and PBMs use their own MAC benchmarks to ensure that the pharmacy industry does not overcharge patients for generic medicines. The purpose of a MAC list is to incentivize pharmacies to negotiate more competitive rates for generic drugs with manufacturers and wholesalers to keep overall prices down. By inhibiting the ability for PBMs to control the prices of generic drugs, these restrictions will increase costs for individuals, employers, and small businesses.

H1234 requires health plans to apply cost-sharing assistance amounts, including drug manufacturer coupons, towards a member's required contribution to deductible and annual out-of-pocket maximum. This provision would permanently assist drug companies in selling high-cost brand name drugs at the expense of more cost-effective generics. Copayment assistance programs and drug coupons may seem like a good deal for consumers; however, drugmakers use coupons as an incentive for patients to use branded drugs instead of less expensive generics, even though a less expensive and equally effective alternative may be available, insulating patients from the true cost of a drug. But while the consumer may pay a lower copayment for a short amount of time, health plans pay significantly more for the higher-cost drug covered by the coupon. Therefore, limiting consumer exposure to cost-sharing will only shift the waived costs charged by pharmaceutical manufacturers to employers and consumers through increased monthly health insurance premiums. **Coupons have reduced the use of generic drug competitors and increased branded drug sales by more than 60%, and increased brand drug makers' revenue by $700 million to $2.7 billion, an average windfall of $30 to $120 million per drug.**

Finally, H1234 imposes exorbitant financial penalties on both health plans and PBMs for non-compliance. The financial penalty would equal to 10% of a health plan's or PBM's aggregate pharmacy reimbursement in a year. Carriers will not be responsible for financial penalties unless the contract expressly permits the conduct. While the language potentially exempts carriers from the financial penalties if the contract does not permit the prohibited conduct, the penalties set forth in the bill are massive and would jeopardize the stability of the health insurance market if applied. **A financial penalty equal to 10% of a health plan's aggregate pharmacy reimbursement in a year could equal hundreds of millions of dollars per plan and deplete health plan reserves. For example, a health plan with $1.3 billion in aggregate pharmacy reimbursements could be required to pay a $130 million penalty.**

H1234, H1235, H1364, and S724 would raise costs for employers and consumers by restricting important tools used by health plans and PBMs to keep costs down. **For these reasons, we OPPOSE House Bills 1234, 1235, 1364 and Senate Bill 724.**

House No. 1157 / Senate No. 831, An Act to ensure access to prescription medication and community pharmacies; House No. 1322 / Senate No. 734, An Act ensuring access to specialty medications; Senate No. 687, An Act ensuring access to fair and reasonable pharmacy networks; and Senate No. 777, An Act relative to specialty medications and patient safety – Oppose

H1157, H1322, S687, S734, S777, and S831 would frustrate the ability for health plans and PBMs to bring down health care costs by establishing high quality and affordable networks though prohibiting the use of financial incentives, including co-payments and deductibles, to encourage the use of specific pharmacy providers, including specialty and mail order pharmacies, to encourage utilization of high quality, more cost-effective network pharmacies and by imposing so-called "any willing" pharmacy requirements for specialty drugs. The bills will jeopardize patient safety and quality of care and have a material increase on health care costs.

Health plans contract with specialty pharmacies because of their expertise in coordinating the often-complex delivery and treatment processes associated with these drugs that is unsurpassed in other settings, making them better suited than other pharmacies to handle the distribution of these drugs. Health plans and PBMs further require network specialty pharmacies to be accredited by a national accrediting body, Utilization Review Accreditation Commission (URAC) to ensure that the pharmacy complies with strict quality and safety standards. The bills do not require specialty pharmacies to obtain accreditation to operate in the state, and the licensure requirements outlined in H1322 are less stringent than the national accreditation standards.

The bills will materially increase health care costs. Any willing pharmacy laws diminish the ability of health plans (and their PBMs) to drive value and provide lower cost options for their members. Our members have estimated that "any-willing specialty pharmacy" requirements could add as much as 3% on top of pharmacy spend and increase health care costs by hundreds of millions of dollars.

As the HPC has found, the cost of specialty drugs has risen significantly both in terms of individual price and demand for these expensive drugs. Specialty drugs account for roughly 2-3% of drugs; however, the costs associated with these drugs represent 50% of the pharmacy spend in Massachusetts. And newer drugs coming to market tend to fall into this category. The HPC has reported that in 2022, spending on clinician-administered drugs represented 7.3% of total commercial spending.

H1322 directs the Board of Registration in Pharmacy to establish a licensure category for specialty pharmacies. The Board is also charged with defining "specialty drugs". We have serious concerns with granting the Board of Registration in Pharmacy the authority to establish a Massachusetts-specific definition of "specialty drugs". This could lead to inconsistencies in the application of specialty pharmacy requirements and instances where drugs that are provided through specialty pharmacies today are no longer deemed a specialty drug by the Board. This will enable retail, as well as hospital and physician operated pharmacies, to dispense the drug at a much higher price without adhering to quality and safety standards. It will also, as mentioned above, enable hospital and physician pharmacies to buy and bill expensive drugs at inflated prices. Robust accreditation requirements governing quality, safety, and patient assistance exist today. **Should Massachusetts move forward with establishing a licensure process for specialty pharmacies, the state should either leave the definition out of the legislation, thereby deferring to national accreditation standards, or reference the federal definition established by CMS.**

Prohibiting health plans from utilizing exclusive specialty network pharmacies would undercut health plans efforts to contain rising prescription drug costs, while also endangering patient safety and the proper handling of expensive and complex drugs. **For these reasons, we OPPOSE House Bill 1157, House Bill 1322, Senate Bill 687, Senate Bill 734, Senate Bill 777, and Senate Bill 831.**

House No. 1082, An Act to enact the pharmacy benefit manager compensation reform – Oppose
H1082 is unnecessary and premature, as the PACT Act already established a pharmacy benefit manager (PBM) licensure framework that has yet to be fully implemented. Introducing additional requirements before the existing law is operational would create unnecessary confusion, increase administrative burden, and potentially interfere with the contractual relationships between PBMs and health carriers. Rather than layering new mandates, efforts should focus on finalizing and evaluating the implementation of the PACT Act provisions to ensure an effective regulatory approach. **For these reasons, we OPPOSE House Bill 1082.**

House No. 1125 / Senate No. 693, An Act relative to non-medical switching – Oppose
H1125 and S693 would result in increased health care costs for consumers and small businesses by limiting the tools available to health plans to manage the rising price of prescription drugs. These bills are unnecessary, as the Step Therapy Law, Chapter 176O of the Acts of 2022, already requires carriers to

maintain continuity of care policies to ensure patients do not experience delays in accessing prescribed medications while an exception request is under review. These bills would prevent health plans from excluding coverage of a prescription drug, or changing the tier or cost sharing, for all members who are medically stable on a drug, thereby eliminating the ability for health plans to develop and manage prescription drug formularies. Formulary management is a tool routinely utilized by health plans, pharmacy benefit management companies, hospitals, and government agencies, including the Medicare and Medicaid programs, Veterans Health Administration, and Department of Defense to address the high cost of prescription drugs and ensure access to high quality care for patients.

Formulary management promotes the use of clinically appropriate pharmacy options, while respecting the physician's prescribing authority. The use of formularies ensures high-quality, evidence-based clinical decisions and enables physicians, pharmacists, and other health care professionals to promote clinically sound, cost-effective medication therapy and positive therapeutic outcomes. In developing formularies, health plans evaluate covered drugs and cost sharing on a regular basis, working closely with local practicing physicians and pharmacists to determine medical appropriateness and efficacy. Health plans change drugs on their formulary to ensure more effective results for members and to achieve cost savings for the employers and individuals who purchase coverage. In addition, all health plans have an exceptions process in place for physicians to request and receive an exception to a formulary coverage determination where there is a clinically valid reason for prescribing a drug, as well as continuity of care programs to address situations where a drug was covered under a prior plan. It is important to note that an effective formulary management strategy, used in concert with other cost mitigation programs, can yield significant savings for employers and patients, while still preserving access to medication. As such, H1125 and S693 are duplicative, and would undermine health plans' ability to develop and manage formularies effectively. **For these reasons, we OPPOSE House Bill 1125 and Senate Bill 693.**

House No. 1133, An Act relative to patient financial protection – Oppose
H1133 would require health plans to establish a separate out-of-pocket (OOP) limit for prescription drugs, including specialty drugs. H1133 is unnecessary as Both the Minimum Creditable Coverage (MCC) requirements established by the Health Connector and the Essential Health Benefit (EHB) requirements under the federal Affordable Care Act (ACA) establish regulatory limitations on a member's exposure to OOP expenses. The ACA is very prescriptive in defining the total maximum copayments, coinsurance, and deductibles that an individual will be responsible for in a given year and strictly limits cost-sharing to reduce the member's financial burden. Each enrollee's OOP costs for health care, including all member spending for prescription drugs, may not exceed a certain dollar amount every year. Further, the ACA prohibits health plans from imposing any cost sharing for countless preventive services. We recognize the challenges that individuals face due to the rising costs of health care and prescription drugs. However, this bill fails to address the underlying costs of pharmaceutical drugs and the exorbitant increases in the prices pharmaceutical companies charge for prescriptions. High drug prices are a major contributor to health insurance premium increases and high out-of-pocket costs, placing a financial burden on patients, families, and the health care system. **For these reasons, we OPPOSE House Bill 1133.**

House No. 1155 / Senate No. 694, An Act empowering health care consumers – Oppose
H1155 and S694 would require health plans to make prescription drug formularies available to members and are unnecessary, as the information referenced is already provided to individuals in Massachusetts in accordance with state and federal law, but they will also result in increased administrative costs should implementation of a separate standard format be mandated.

In accordance with the Affordable Care Act (ACA), all health plans must publish an up-to-date, accurate, and complete list of all covered drugs on its formulary, including any tiering structure that it has adopted and any restrictions on the way a drug can be obtained, in a manner that is easily accessible to plan enrollees, prospective enrollees, and the general public. Federal regulations provide that a formulary drug list must be

posted on the plan's public website through a clearly identifiable link or tab without requiring an individual to create or access an account or enter a policy number. The ACA specifically prescribes the format to health plans for sharing this information on their prescription drug formularies. Chapter 176O of Massachusetts General Laws and 211 CMR 52.13 also require health plans to provide detailed information to their members and to eligible consumers through Evidences of Coverage which contain information on the scope of services and benefits available, including cost and network information and a complete list of prescription drugs that are included or excluded from any formulary. Every formulary must be updated within 48 hours of any effective change, and plans must provide a toll-free number to enable insureds to determine whether a particular drug is included in or excluded from the closed or restricted formulary. Plans must also update their websites as soon as practicable relative to any change in the formulary to enable members to determine whether a particular drug is included in or excluded from the formulary allowing 24/7 access to drug coverage information for members, providers, or their designated representatives. Existing federal and state laws and regulations are very prescriptive on requiring health plans to share lists of covered drugs in a closed or restricted formulary which an eligible consumer can access through multiple channels. As such, these bills are unnecessary in the light of existing state and federal requirements that already make this information available to consumers in a clear and understandable format for use in comparing plan coverage. **For these reasons, we OPPOSE House Bill 1155 and Senate Bill 694.**

House No. 1274, An Act prohibiting PBMs from discriminating against hospitals and patients participating in the 340B drug discount program – Oppose

H1274 would prohibit health plans and their PBMs from imposing different requirements on providers based on the provider's 340B status, thereby limiting the ability for health plans and PBMs to develop networks, impose cost sharing, or other requirements that control costs and ensure quality. Health plans and their PBM partners design pharmacy programs to ensure savings and incentivize members to utilize clinically appropriate and low-cost prescription drugs and pharmacies, including specialty pharmacies. While we do not believe the intent of the language was to be overly prescriptive, the current draft would significantly constrain this work and increase costs. We look forward to working with the bill's sponsors to develop alternative language that achieves the intended goals without these unintended consequences. **For these reasons, we OPPOSE House Bill 1274.**

House No. 1305 / Senate No. 781, An Act to help patients and reduce health care costs by ensuring patient adherence to medications – Oppose

H1305 and S781 would increase health care costs by requiring health plans to prorate copayments and pay the full amount of a dispensing fee every time a pharmacy partially fills a prescription. Health plans negotiate with pharmacies to build networks and set reimbursement terms, including ingredient costs and dispensing fees, which are meant to cover the pharmacy's dispensing-related costs beyond the drug itself. Proponents of House Bill 1305 and Senate Bill 781 argue the bills would improve coordination and compliance by synchronizing medication timing, but the dispensing fee has nothing to do with compliance, and synchronization is often unachievable. These bills would allow pharmacies to receive full dispensing fees for partial fills, creating a misalignment between services provided and reimbursement. Additionally, they misunderstand how copayments are determined, which are generally based on the type and cost of the drug, not the quantity dispensed, and would increase administrative burden for all involved. Rather than mandating reimbursement levels, dispensing fees and copayments for partial fills should be determined through contract negotiations. **For these reasons, we OPPOSE House Bill 1305 and Senate Bill 781.**

House No. 1324, An Act relative to prescription drug pricing; House No. 1330, An Act relative to pharmacy benefit managers reimbursements to pharmacies in the Commonwealth; and Senate No. 830, An Act to preserve community pharmacies – Oppose

H1324, H1330, and S830 would restrict the ability of health plans and their pharmacy benefit managers (PBMs) to manage pharmacy costs and ensure access to safe, effective, and affordable prescription drugs.

These bills would prohibit health plans and PBMs from requiring pharmacies in their network to meet national accreditation standards beyond what is required by the state or federal government. This would jeopardize patient safety and undermine quality standards currently used to ensure proper handling of complex medications, particularly through specialty and mail-order pharmacies. Today, many health plans rely on accreditation by organizations like URAC, which set higher benchmarks for safety, such as 24/7 support, strict storage protocols, and care coordination. Specialty drugs often require close clinical oversight, and allowing pharmacies without such accreditation to dispense these drugs may compromise care and outcomes.

These bills would also impose extensive requirements on how PBMs develop, manage, and disclose maximum allowable cost (MAC) pricing lists. These lists are a standard tool used by health plans and PBMs to ensure fair reimbursement for generic drugs, promote competition, and contain costs. The bills would require PBMs to disclose proprietary methodologies and adjust prices retroactively across entire pharmacy networks when a single pharmacy appeals. This creates significant administrative burdens and undermines the core purpose of MAC pricing—encouraging pharmacies to negotiate better prices with wholesalers. These mandates could inadvertently drive up costs for consumers, employers, and the Commonwealth. Notably, the Federal Trade Commission has cautioned that forced disclosure of proprietary pricing information can have anti-competitive effects, potentially increasing drug prices.

While the bills include provisions for transparency and appeals processes that we do not oppose in principle, several mandates go too far and would impair the ability of health plans to responsibly manage pharmacy benefits. Health plans already reimburse pharmacies through models that account for acquisition costs, dispensing fees, and service levels—models that work when market-based negotiation is preserved.

H1324, H1330, and S830 would significantly curtail the few tools available to health plans to manage drug costs responsibly. At a time when affordability remains one of the most pressing concerns for Massachusetts residents and employers, this bill would increase prescription drug spending and reduce safeguards for quality care. **For these reasons, we OPPOSE House Bill 1324, House Bill 1330, and Senate Bill 830.**

House No. 1222, An Act relative to prescription medication re-authorization – Oppose
H1222 would eliminate the ability of health plans to effectively ensure the provision of affordable, evidence-based, high-quality care to Massachusetts residents through the use of utilization management practices by prohibiting health plans from requiring prior authorization for any prescription drug used to treat any chronic disease. Prior authorization and other utilization management practices are tools used by health plans to protect patients, reduce medical expenses, and prevent fraudulent care. When employers purchase health insurance coverage, they expect health plans to utilize these tools to ensure that their employees can access safe, evidence-based, and cost-effective care at the right time and in the right setting. Health plans and government programs use prior authorization in limited circumstances to lower patient's out of pocket costs, prevent misuse, overuse, and unnecessary or potentially harmful care, and to ensure that care is consistent with evidence-based practices.

To ensure that the right care is delivered at the right time in the right setting and covered at a cost that consumers and employers can afford, health plans use utilization management tools including prior authorization, retrospective review, and concurrent review to ensure access to safe, evidence-based, and affordable health care. These utilization management tools allow health plans to provide proper intervention in areas including unnecessary care and misuse. Physicians themselves estimate that nearly a quarter of services are unnecessary, including 22% of prescription medications. These tools also allow health plans to protect patients against harmful care and inappropriate care such as exposure to unnecessary radiation, missed diagnoses and false positives, and ineffective procedures and treatments.

The use of utilization management tools, including prior authorization and step therapy protocols, is heavily regulated in Massachusetts, with requirements under Chapter 176O of the Massachusetts General Laws for health plans to follow national, evidence-based standards of care. Filed with the Division of Insurance and publicly available, health plan prior authorization requirements are updated at least biennially as new treatments, applications and technologies are adopted as generally accepted professional medical practice. Further, health plans are already required by state law to respond to a complete prior authorization request within two business days. Moreover, the health plan's decision is not the final decision, as members always have the right to seek an appeal by an external independent organization through a process that is governed by state and federal law and accreditation standards. **For these reasons, we OPPOSE House Bill 1222.**

House No. 4043, An Act relative to copay assistance for medications – Oppose

H4043 would increase premiums and health care costs by establishing copay assistance programs that would assist drug companies in selling high-cost brand name drugs at the expense of more cost-effective generics. Copayment assistance programs and drug coupons may seem like a good deal for consumers; however, drugmakers use coupons as an incentive for patients to use branded drugs instead of less expensive generics, even though a less expensive and equally effective alternative may be available, insulating patients from the true cost of a drug. But while the consumer may pay a lower copayment for a short amount of time, health plans pay significantly more for the higher-cost drug covered by the coupon. Therefore, limiting consumer exposure to cost-sharing will only shift the waived costs charged by pharmaceutical manufacturers to employers and consumers through increased monthly health insurance premiums. Coupons have reduced the use of generic drug competitors and increased branded drug sales by more than 60%, and increased brand drug makers' revenue by $700 million to $2.7 billion, an average windfall of $30 to $120 million per drug. Allowing coupons and cost-sharing assistance from drug manufacturers removes the patient's incentive to choose the lower cost alternative and as Massachusetts works to control rising health care costs and improve affordability, it must avoid policies that would drive up premiums and overall health care costs for employers and consumers. **For these reasons, we OPPOSE House Bill 4043.**

Support

House No. 1092, An Act to ensure affordable prescription medications through accountability standards – Support

Prescription drug costs are one of the fastest growing drivers of health care spending in Massachusetts and across the country. Health plans have limited tools to control drug spending. Despite developing formularies, utilization management, and promotion of lower cost options such as generics, payors are at the mercy of drug manufacturers, particularly for brand-name and specialty drugs. Given that health care prices in Massachusetts continue to exceed the state's health care cost growth benchmark, it is imperative that we take meaningful action to make health care coverage more affordable. Health care cost containment is a shared responsibility among all players in the health care sector. The PACT Act, Chapter 342 of the Act of 2024, represented a good first step.

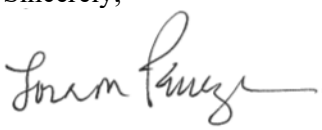
H1092 includes provisions that represent the next phase in providing greater transparency and accountability over drug costs by expanding the HPC's drug pricing review authority to drugs impacting the commercial market. This bill empowers the Health Policy Commission to obtain detailed information from pharmaceutical manufacturers about their pricing practices and assess whether certain prescription drugs are priced unreasonably or excessively based on data such as wholesale acquisition cost trends, research and development expenditures, and manufacturer justifications. It also ensures an informed review process by allowing input from patients, providers, provider organizations, and payers along with insights from independent cost-effectiveness research that will help ensure that drug prices reflect their clinical value. Expanding the monitoring authority of the Attorney General and CHIA to include prescription drugs is essential to understanding the full picture of health care spending and developing effective strategies to improve affordability for consumers and employers. **For these reasons, we SUPPORT House Bill 1092.**

For the above reasons, we urge the Committee to **oppose the following bills: House Nos. 1082, 1125, 1133, 1155, 1157, 1222, 1234, 1274, 1305, 1322, 1324, 1325, 1330, 1364 and 4043, and Senate Nos. 687, 693, 694, 724, 734, 777, 781, 830, and 831.**

Conversely, for the above reasons, we urge the Committee to **support House No. 1092.**

Thank you for the opportunity to share our concerns. Please do not hesitate to contact me for additional information or to discuss these bills further.

Sincerely,



Lora M. Pellegrini, President and CEO
Massachusetts Association of Health Plans