Frequently Asked Questions About
Chapter 342 of the Acts of 2024 and
Coverage for Certain Prescription Drugs to Treat Certain Chronic Conditions

Chapter 342 of the Acts of 2024 includes a mandate that insurance carriers place limitations on the copayments that apply to certain prescription drugs to treat certain chronic conditions. The provisions of the law and carrier responsibilities are described in Policy Filing Guidance 2025-E.[1]

The Division of Insurance developed the following Q&A to help providers and consumers understand mandated coverage for prescription drugs to treat these certain chronic diseases. This mandate applies to fully insured health plans issued under Massachusetts law by insurance companies, Blue Cross and Blue Shield of Massachusetts, and Health Maintenance Organizations (collectively referred to as "Insurance Carriers").

DIFFERENT TYPES OF HEALTH PLANS

Does the mandated benefit for prescription drugs for chronic diseases apply to all health plans?
No.

This mandate DOES apply to all fully insured health benefit plans delivered, issued or renewed by insurance companies, BCBSMA, and Health Maintenance Organizations ("HMOs") in the Commonwealth. This includes health plans purchased through the Massachusetts Health Connector (e.g., all ConnectorCare Health Plans). The mandate also applies to certain insured HMO plans issued in other states that cover Massachusetts residents.[2]

This mandate DOES NOT apply to the majority of insured health benefit plans issued or renewed to employers located outside of Massachusetts even if the covered person lives in Massachusetts. Coverage issued outside of Massachusetts is subject to the laws in the state in which the employer purchases the coverage.

This mandate DOES NOT apply to employment-sponsored health plans where the employer/union sponsoring the plan self-funds the cost of health benefits rather than buying insured coverage from an insurance carrier. These self-funded plans are exempt from state insurance laws under federal ERISA[3] law and instead are regulated by the federal Department of Labor.

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[1] https://www.mass.gov/doc/filing-guidance-notice-2025-e-prescription-benefits-for-chronic-conditions-pursuant-to-sections-32-36-of-chapter-342-of-the-acts-of-2024/download, which is based on the provisions of M.G.L. c. 175, §47CCC; M.G.L. c. 176A, §8DDD; M.G.L. c. 176B, §4DDD; and M.G.L. c. 176G, §4VV.

[2] Persons may receive this pain management coverage if they are covered under an insured plan issued outside Massachusetts that is issued to an HMO licensed in Massachusetts. For example, some persons may be covered through a workplace in New Hampshire or other state by a health insurance carrier that is required to comply with the provisions of this law.

[3] Employee Retirement and Income Security Act of 1994.

This mandate DOES apply to some state government programs (e.g., MassHealth and plans offered by the Group Insurance Commission); however, these programs are not subject to Division of Insurance jurisdiction or authority.

This mandate DOES NOT apply to Medicare plans, including Medicare Advantage Plans (Medicare Part C) and Prescription Drug Plans (Medicare Part D) which, as federal programs, are exempt from Massachusetts insurance laws.

How can individuals know if their health plan is fully insured and subject to this mandate?

Individuals should contact their employer's human resources representative, the agency sponsoring a health plan, or their health insurance plan to understand whether they are in an insured health benefit plan issued in Massachusetts that is subject to the protections of the law. Since many people are covered under self-funded plans or plans that are issued outside Massachusetts that are exempt from this law, it is important to understand whether the mandate applies to your coverage.

PRESCRIPTION DRUG BENEFIT FOR CHRONIC DISEASES

How does the prescription drug benefit for chronic diseases change with this law?

Insured health benefit plans issued, delivered, or renewed in Massachusetts are to do the following:

> shall identify 1 generic drug and 1 brand name drug [where available] used to treat each of the following chronic conditions: (i) diabetes; (ii) asthma; and (iii) the 2 most prevalent heart conditions among its enrollees [and] shall identify insulin as the drug used to treat diabetes [and the] coverage for the identified generic drugs [for chronic conditions] shall not be subject to [any] cost-sharing [and c]overage for identified brand name drugs [for chronic conditions] shall not be subject to any deductible or co-insurance and any co-payment shall not exceed $25 per 30-day supply.

How do insurance carriers choose the identified generic and brand-name drug?

In determining the 1 generic drug and 1 brand name drug used to treat each chronic condition, the law indicates that "carrier shall consider whether the drug is: (i) of clear benefit and strongly supported by clinical evidence to be cost-effective; (ii) likely to: (A) reduce hospitalizations or emergency department visits; (B) reduce future exacerbations of illness progression; or (C) improve quality of life; (iii) cost effective for the carrier and its enrollees; (iv) at low risk for overutilization, abuse, addiction, diversion or fraud; and (v) one of the most widely utilized as a treatment for the chronic condition."

It is also noted in the law that the Division of Insurance "shall review the drugs to verify that the selected drugs meet the criteria identified in those sections…[and s]hould a selected drug be

deemed by the [Division of Insurance] to not meet the criteria, the commissioner may require a different drug to be selected."

How will I know which prescription drugs are subject to cost-sharing limitations?

Carriers are expected to publicly identify the drugs selected as generic and brand-name drugs to treat the specified chronic conditions. The Division of Insurance will also aggregate information among all the insurance carriers and will publish this information on its website annually.

What is the identified drug to treat diabetes?

Insulin is the prescription drug to treat diabetes. However, insulin is presented as a biosimilar drug, not as a generic drug, and this law does not apply to biosimilars. Therefore, under this law health plan members may request their provider to prescribe them the brand-name insulin drug(s) that is available with a $25 copay, but members should not expect to receive their insulin prescriptions without any cost-sharing.

Will there always be 1 generic and 1 brand-name listed for each chronic condition?

Carriers are expected to publicly identify all drugs selected as generic and brand-name drugs to treat the specified chronic conditions. If a carrier can substantiate that there are no generic or brand-name drugs to treat a chronic condition, then the mandate will have no effect on cost sharing for that drug, and health plan members should not expect to receive reductions in their copayments or other cost-sharing requirements not in.

The law indicates that the copayment limitations do not apply to a plan governed by the Internal Revenue Code and would lose its tax-exempt status as a result of cost-sharing restrictions. Which plans fall under this exemption?

Certain plans are identified as High-Deductible Health Plans (HDHP) under federal tax law (the Internal Revenue Code) when they are offered with federally tax-advantaged Medical Savings Accounts. A plan qualifies as an HDHP when cost-sharing applies to all benefits except for federally identified preventive care benefits. Since most prescription drugs are not considered preventive care benefits, a plan would likely not qualify as an HDHP if it limited prescription drug copayments as identified in the law, and this could impact the tax advantages of Medical Savings Accounts. Therefore, members of HDHPs should contact their employer's human resources representative or their health plan with questions regarding the applicability of this law to their HDHP.

Which chronic diseases are covered under the law?

The law applies to (1) diabetes, (2) asthma, and (3) the 2 most prevalent heart conditions among its enrollees. Regarding heart conditions, this may vary from one insurance carrier to another based on which heart conditions are most prevalent among a carrier's enrollees. In annual filings, each insurance carrier will be expected to update the 2 most prevalent heart conditions among its

enrollees and make covered persons aware of which heart conditions will apply in the upcoming year.

Do the copayment restrictions apply to all prescriptions to treat chronic disease?
No, in annual filings, carriers are required for each specific chronic disease to identify, where available, the one generic and one brand-name prescription drug from their formulary that will be subject to the copayment restrictions. The identified generic and brand-name prescription drug may vary from one insurance carrier to another. It is important to understand each carrier's identified list, especially when considering switching from one insurance carrier to another.

Other than the generic and prescription drugs identified, carriers' formularies may include other generic or brand-name prescription drugs to treat the noted chronic diseases. These other prescription drugs are not required to meet the copayment restrictions and instead will be subject to the cost sharing that is part of the insured's benefit plan. It is important to understand which prescription drugs are on the identified list and talk with your care provider about whether drugs with limited copayment levels may be appropriate for your treatment.

If I am approved to use a prescription drug other than those on the identified list after going through step therapy protocols, does my drug then automatically qualify for copayments that apply to those prescription drugs on the identified list?
No, the law does not provide for carriers to apply the copayment limitations to any prescription drugs other than those that are on the identified list. If you are approved for other prescription drugs following carrier step therapy or other approval protocols, the insurance carrier is not required to apply the copayment limitation to your new prescription drug.

How often do the identified generic and prescription drug plan change?
Insurance carriers are to review their identified list not more frequently than annually except in the following circumstances:

- An identified prescription drug is taken off the market by the drug manufacturer; or
- The price of an identified prescription drugs is substantially changed by the drug manufacturer,

If an insurance carrier wishes to change the identified prescription drugs, it will notify the Division in writing of a material change, which the Division will then review.

How may my prescription drug copayments be impacted if I change health plans?

It will be important to inquire about coverage under a potential new plan to understand if it may impact the copayments that you may pay for the identified chronic disease prescription drugs, especially regarding the following:

- if an individual switches to a health plan that is not subject to the law – e.g., it is a self-funded health plan – the individual may pay different cost-sharing (deductibles,

coinsurance or copayments) based on the benefits of the coverage. If an individual switches to an insured health plan, the individual may be subject to different health plan cost-sharing (deductibles, coinsurance or copayments) if the insurance carrier is not subject to the law.

- Even if an individual switches coverage to an insured health plan that is subject to the law, the individual may be subject to different levels of cost-sharing if the new plan identifies different generic or prescription drugs to treat certain chronic conditions than identified by the existing plan. An individual may also be subject to different levels of cost-sharing for heart-condition drugs if the new plan has identified different heart conditions or drugs than those that were identified by the existing plan.

If there are additional questions, please contact Niels Puetthoff, Director, Bureau of Managed Care, at niels.puetthoff@mass.gov.