

HOUSE No. 4493

The Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES, September 18, 2025.

The committee on Financial Services, to whom was referred the petition (accompanied by bill, House, No. 1157) of Carole A. Fiola and Patrick Joseph Kearney relative to prescription medication and community pharmacies, reports recommending that the accompanying bill (House, No. 4493) ought to pass.

For the committee,

JAMES M. MURPHY.

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

An Act to ensure access to prescription medication and community pharmacies.

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

1 SECTION 1. Chapter 175 of the General Laws is hereby amended by adding the
2 following new section:-

3 Section 226A Contracts for Community Pharmacy Services

4 “Brand name drug”, a drug that is: (i) produced or distributed pursuant to an original new
5 drug application approved under 21 U.S.C. 355(c) except for: (A) any drug approved through an
6 application submitted under section 505(b)(2) of the Federal Food, Drug, and Cosmetic Act that
7 is pharmaceutically equivalent, as that term is defined by the United States Food and Drug
8 Administration, to a drug approved under 21 U.S.C. 355(c); (B) an abbreviated new drug 407
9 application that was approved by the United States Secretary of Health and Human Services
10 under section 505(c) of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 355(c), before the
11 date of the enactment of the federal Drug Price Competition and Patent Term Restoration Act of
12 19 of 58 1984, Public Law 98-417, 98 Stat. 1585; or (C) an authorized generic drug as defined in
13 42 C.F.R. 447.502; (ii) produced or distributed pursuant to a biologics license application

14 approved 412 under 42 U.S.C. 262(a)(2)(C); or (iii) identified by the health benefit plan as a
15 brand name drug based on available data resources such as Medi-Span.

16 “Generic drug”, a retail drug that is: (i) marketed or distributed pursuant to an
17 abbreviated new drug application approved under 21 U.S.C. 355(j); (ii) an authorized generic
18 drug as defined in 42 C.F.R. 447.502; (iii) a drug that entered the market before January 1, 1962
19 and was not originally marketed under a new drug application; or (iv) identified by the health
20 benefit plan as a generic drug based on available data resources such as Medi-Span.

21 “Pharmacy Audit”, a process that involves the inspection of pharmacy records to ensure
22 high quality services and the lack of Fraud Waste, and Abuse. This includes desk audits as well
23 as in-person audits.

24 “Pharmacy Benefit Manager” as defined in MGL c 175 Section 226 (a).

25 Pharmacy Steering” A practice employed by a pharmacy benefit manager or carrier that
26 channels a prescription to a pharmacy in which a pharmacy benefit manager or carrier has an
27 ownership interest, and includes and is not limited to retail, mail order, or specialty pharmacy.

28 “Specialty Medications” medications that have a complex profile that require intensive
29 patient management or special handling.

30 Section 1: Network Pharmacies and Payment for pharmacy services

31 A contract for pharmacy services between a pharmacy benefit manager and a pharmacy
32 must include an ingredient cost that meets the criteria in section 3E and a dispensing fee equal be
33 no less than what is paid by the State Medicaid Program. Payment for clean claims must include

34 all applicable discounts. Contracts that include retroactive discounts and use “Generic Effective
35 Rate” or “Brand Effective Rate” or any other similar retroactive rate reductions are prohibited.

36 Payment for pharmacy services to non-affiliated pharmacies must be equal to or greater
37 than payment to pharmacies affiliated with or owned by the pharmacy benefit manager.

38 A pharmacy benefit manager shall not engage in pharmacy steering.

39 A pharmacy benefit manager must allow any pharmacy licensed in Massachusetts to
40 provide any medication including “specialty medications” if the pharmacy is willing to provide
41 the required services. The required services must be the same among all pharmacies.
42 Requirements to provide specialty pharmacy medications cannot be designed to exclude
43 community pharmacies

44 Section 2: Ingredient and Maximum Allowable Cost

45 (a) For the purposes of this section the term "maximum allowable cost list" shall mean a
46 list of drugs, medical products or devices, or both medical products and devices, for which a
47 maximum allowable cost has been established by a pharmacy benefits manager or covered entity.
48 The term "maximum allowable cost" shall mean the maximum amount that a pharmacy benefits
49 manager or covered entity will reimburse a pharmacy for the cost of a drug or a medical product
50 or device inclusive of all discounts when the claim is processed or taken retroactively.

51 (b) The maximum allowable cost (if used) or the ingredient cost (if not used) must be equal
52 to or greater than the cost used by the Massachusetts Medicaid Program

53 (c) The maximum allowable cost for non-affiliated pharmacies must be equal to or
54 greater than the maximum allowable cost to pharmacies affiliated with or owned by the
55 pharmacy benefit manager.

56 (d) Before a pharmacy benefits manager or covered entity may place a drug on a
57 maximum allowable cost list the drug must be listed as "A" or "AB" rated in the most recent
58 version of the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations, also
59 known as the Orange Book, or has an "NR" or "NA" rating or a similar rating by a nationally
60 recognized reference; and that there are at least two therapeutically equivalent, multiple source
61 drugs, or at least one generic drug available from one manufacturer, available for purchase by
62 network pharmacies from national or regional wholesalers registered in Massachusetts.

63 (e) A pharmacy benefits manager or covered entity shall make available to each
64 pharmacy with which the pharmacy benefits manager or covered entity has a contract and to
65 each pharmacy included in a network of pharmacies served by a pharmacy services
66 administrative organization with which the pharmacy benefits manager or covered entity has a
67 contract, at the beginning of the term of a contract upon renewal of a contract, or upon request:

68 (1) The sources used to determine the maximum allowable costs for the drugs and
69 medical products and devices on each maximum allowable cost list;

70 (2) Every maximum allowable cost for individual drugs used by that pharmacy benefits
71 manager or covered entity for patients served by that contracted pharmacy; and

72 (3) Upon request, every maximum allowable cost list used by that pharmacy benefits
73 manager or covered entity for patients served by that contracted pharmacy.

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75 (e) A pharmacy benefits manager or covered entity shall:

76 (1) update each maximum allowable cost list at least every 3 business days

77 (2) Make the updated lists available to every pharmacy with which the pharmacy benefits
78 manager or covered entity has a contract and to every pharmacy included in a network of
79 pharmacies served by a pharmacy services administrative organization with which the pharmacy
80 benefits manager or covered entity has a contract, in a readily accessible, secure and usable web-
81 based format or other comparable format or process; and

82 (3) Utilize the updated maximum allowable costs to calculate the payments made to the
83 contracted pharmacies within 2 business days.

84 (f) A pharmacy benefits manager or covered entity shall establish a clearly defined
85 process through which a pharmacy may contest the cost for a particular drug or medical product
86 or device.

87 (g) A pharmacy may base its appeal on one or more of the following:

88 (1) The ingredient cost established for a particular drug or medical product, or device is
89 below the cost used by the Massachusetts Medicaid Program

90 (2) The pharmacy benefits manager or covered entity has placed a drug on the maximum
91 allowable cost list that does not meet the requirements of subsection (d).

92 (h) The pharmacy must file its appeal within seven business days of its submission of the
93 initial claim for reimbursement for the drug or medical product or device. A Pharmacy Services

94 Administrative Organization (PSAO) may appeal on behalf of a pharmacy or group of
95 pharmacies. The pharmacy benefits manager or covered entity must make a final determination
96 resolving the pharmacy's appeal within seven business days of the pharmacy benefits manager or
97 covered entity's receipt of the appeal.

98 (i) If the final determination is a denial of the pharmacy's appeal, the pharmacy benefits
99 manager or covered entity must state the reason for the denial and provide the national drug code
100 of an equivalent drug that is generally available for purchase by pharmacies in this state from
101 national or regional wholesalers licensed by the state at a price which is equal to or less than the
102 cost for that drug.

103 (j) If a pharmacy's appeal is determined to be valid by the pharmacy benefits manager or
104 covered entity, the pharmacy benefits manager or covered entity shall retroactively adjust the
105 cost of the drug or medical product or device and reprocess all claims that were paid incorrectly.
106 The adjustment shall be effective from the date the pharmacy's appeal was filed, and the
107 pharmacy benefits manager or covered entity shall provide reimbursement for all reprocessed
108 claims.

109 (k) Once a pharmacy's appeal is determined to be valid by the pharmacy benefits manager
110 or covered entity, the pharmacy benefits manager or covered entity shall adjust the cost of the
111 drug or medical product or device for all similar pharmacies in the network as determined by the
112 pharmacy benefits manager within 3 business days.

113 (l) A pharmacy benefits manager or covered entity shall make available on its secure web
114 site information about the appeals process, including, but not limited to, a telephone number or
115 process that a pharmacy may use to submit cost appeals. The medical products and devices

116 subject to the requirements of this part are limited to the medical products and devices included
117 as a pharmacy benefit under the pharmacy benefits contract.

118 (m) A pharmacy shall not disclose to any third party the cost lists and any related
119 information it receives from a pharmacy benefits manager or covered entity; provided, a
120 pharmacy may share such lists and related information with a pharmacy services administrative
121 organization or similar entity with which the pharmacy has a contract to provide administrative
122 services for that pharmacy. If a pharmacy shares this information with a pharmacy services
123 administrative organization or similar entity, that organization or entity shall not disclose the
124 information to any third party.

125 (n) If a generic medication is readily available from a wholesaler licensed in
126 Massachusetts, a pharmacy benefit manager is prohibited from requiring the brand name be used
127 or giving any financial incentive to a pharmacy or patient to use the brand name product. The
128 Massachusetts Medicaid program is exempt from this requirement.

129 (o) Pharmacy Benefit Managers shall provide annually a report to the Commissioner that
130 details all denied pharmacy appeals for that year to include: the name of the pharmacy, date of
131 service for the claim, the drug name and billing code used on the claim, the amount billed, the
132 amount paid, and the reason for the denial.

133 Section 3: If during a pharmacy audit, the pharmacy can use signature logs or statements
134 from the prescriber obtained after the audit to validate the intent of a prescription or medication
135 order. If the pharmacy provided the intended medication to the patient but there was a clerical
136 error (with no financial or clinical impact), the pharmacy benefit manager is prohibited from

137 recouping the ingredient cost and can only recoup the dispensing fee. All revenue from
138 pharmacy audits must be given to the plan sponsor.

139 Section 4: A pharmacy benefit manager is prohibited from charging a community
140 pharmacy for credentialing.

141 Section 5: The Insurance Commissioner shall enforce this act and shall promulgate
142 regulations to enforce the provisions of this act. The commissioner may examine or audit the
143 books and records of a pharmacy benefits manager providing claims processing services or other
144 prescription drug or device services for a health benefit plan to determine if the pharmacy
145 benefits manager is in compliance with this act. The information or data acquired during an
146 examination is:

147 (a) Considered proprietary and confidential; and

148 (b) Not subject to the Freedom of Information Act of Massachusetts.