JOINT COMMITTEE ON FINANCIAL SERVICES
2025-2026 (194th) BILL SUMMARY

Bill No: H1125

Title: AN ACT RELATIVE TO NON-MEDICAL SWITCHING

Sponsor: Rep. Michael S. Day (*Stoneham*)

Hearing Date: June 10, 2025

Reporting Deadline: August 9, 2025

Prior History:
2023-24 (H983): Reported favorably; Referred to Health Care Financing; Ordered to a House Study
2021-22 (H1237): Reported favorably; Referred to Health Care Financing; Ordered to a House Study
2019-20 (H949): Ordered to a House Study

Similar Matters: S693 (Crighton – Identical)

CURRENT LAW:
M.G.L. c. 112 Registration of Certain Professions and Occupations §12EE Substitution of interchangeable biological product by pharmacist
(b) Except as provided in subsection (c), a pharmacist filling a prescription for a biological product prescribed by its trade or brand name may substitute an interchangeable biological product.
(c) A pharmacist will not substitute an interchangeable biological product if the prescriber instructs otherwise in writing.

M.G.L. c. 175 Insurance

M.G.L. c. 176A Non-Profit Hospital Service Corporations (Blue Cross of Massachusetts)

M.G.L. c. 176B Medical Service Corporations (Blue Shield of Massachusetts)

M.G.L. c. 176G Health Maintenance Organizations (HMOs)

SUMMARY:
- This bill defines "Nonmedical switching" as a health benefit plan's restrictive changes to the health benefit plan's formulary after the current plan year has begun or during the open enrollment period for the upcoming plan year, causing a covered person who is medically stable on the covered person's current prescribed drug, inclusive of changes to the drug dosage, as determined by the prescribing health care professional, to switch to a less costly alternate prescription drug.

- This bill prevents a health plan, health carrier, or utilization review organization from limiting or excluding coverage of a prescription drug where such organization approved such prescription, and the prescribing physician prescribed the medication to treat a condition within the previous six months. Coverage of the prescription drug will continue through the covered person's last day of eligibility, including any open enrollment period.

- A health carrier, health benefit plan, or utilization review organization will provide a covered person and prescribing health care professional with access to a clear and convenient process to request a coverage exemption determination. Such entities will approve or deny a coverage exemption determination request within 72 hours or under exigent circumstances, within 24 hours. Where a determination is not received within the applicable time, the coverage the exemption will be deemed granted.

- The bill requires a coverage exemption to be expeditiously granted for a health plan discontinued for the next plan year if a covered person enrolls in a comparable plan offered by the same health carrier and in comparison to the discontinued health plan, the new health plan limits or reduces the maximum coverage for a prescription drug, increases cost sharing for the prescription drug, moves the prescription drug to a more restrictive tier, or excludes the prescription drug from the formulary.

    - If a coverage exemption is granted, coverage that is no more restrictive than that offered in the discontinued health benefit plan, or than that which was offered prior to implementation of restrictive changes to the health benefit plan's formulary will be authorized.

    - If a determination is made to deny a request for a coverage exemption, the reason for denial and the procedure to appeal the denial must be provided. Any determination to deny a coverage exemption may be appealed.

    - A health carrier, health benefit plan, or utilization review organization will uphold or reverse a determination to deny a coverage exemption within 72 hours of receipt of an appeal of denial or within 24 hours of receipt if exigent circumstances exist. If the determination to deny a coverage exemption is not upheld or reversed on appeal within the applicable time period, the denial will be deemed reversed, and the coverage exemption will be deemed approved.

    - If a determination to deny a coverage exemption is upheld on appeal, the health carrier, health benefit plan, or utilization review organization will provide the covered person or covered person's authorized representative and the covered person's prescribing health care professional with the reason for upholding the denial on appeal and information regarding the procedure to request external review of the denial. Any denial of a request for a coverage exemption that is upheld on appeal will be considered a final adverse determination and is eligible for a request for external review by a covered person or the covered person's authorized representative.