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State of Minnesota  
**HOUSE OF REPRESENTATIVES**  
*First Division Engrossment*

NINETY-FIRST SESSION

**H. F. No. 1257**

- 02/14/2019 Authored by Cantrell, Hamilton, Mann, Halverson, Baker and others  
The bill was read for the first time and referred to the Committee on Commerce
- 03/04/2019 Adoption of Report: Re-referred to the Committee on Health and Human Services Policy
- 03/18/2019 Adoption of Report: Re-referred to the Committee on Ways and Means

**Division Action**

- Referred by Chair to the Health and Human Services Finance Division*
- 02/27/2020 *Division action, to adopt as amended and return to the Committee on Ways and Means*

1.1 A bill for an act

1.2 relating to health care coverage; requiring prescription drug benefit transparency

1.3 and disclosure; amending Minnesota Statutes 2018, section 256B.69, subdivision

1.4 6; proposing coding for new law in Minnesota Statutes, chapter 62Q.

1.5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

1.6 Section 1. **[62Q.83] PRESCRIPTION DRUG BENEFIT TRANSPARENCY AND**

1.7 **MANAGEMENT.**

1.8 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have

1.9 the meanings given them.

1.10 (b) "Drug" has the meaning given in section 151.01, subdivision 5.

1.11 (c) "Enrollee contract term" means the 12-month term during which benefits associated

1.12 with health plan company products are in effect. For managed care plans and county-based

1.13 purchasing plans under section 256B.69 and chapter 256L, it means a single calendar quarter.

1.14 (d) "Formulary" means a list of prescription drugs that have been developed by clinical

1.15 and pharmacy experts and represents the health plan company's medically appropriate and

1.16 cost-effective prescription drugs approved for use.

1.17 (e) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, and

1.18 includes an entity that performs pharmacy benefits management for the health plan company.

1.19 (f) "Pharmacy benefits management" means the administration or management of

1.20 prescription drug benefits provided by the health plan company for the benefit of its enrollees

1.21 and may include but is not limited to procurement of prescription drugs, clinical formulary

2.1 development and management services, claims processing, and rebate contracting and  
2.2 administration.

2.3 (g) "Prescription" has the meaning given in section 151.01, subdivision 16a.

2.4 Subd. 2. **Prescription drug benefit disclosure.** (a) A health plan company that provides  
2.5 prescription drug benefit coverage and uses a formulary must make its formulary and related  
2.6 benefit information available by electronic means and, upon request, in writing at least 30  
2.7 days prior to annual renewal dates.

2.8 (b) Formularies must be organized and disclosed consistent with the most recent version  
2.9 of the United States Pharmacopeia's Model Guidelines.

2.10 (c) For each item or category of items on the formulary, the specific enrollee benefit  
2.11 terms must be identified, including enrollee cost-sharing and expected out-of-pocket costs.

2.12 Subd. 3. **Formulary changes.** (a) Once a formulary has been established, a health plan  
2.13 company may, at any time during the enrollee's contract term:

2.14 (1) expand its formulary by adding drugs to the formulary;

2.15 (2) reduce co-payments or coinsurance; or

2.16 (3) move a drug to a benefit category that reduces an enrollee's cost.

2.17 (b) A health plan company may remove a brand name drug from its formulary or place  
2.18 a brand name drug in a benefit category that increases an enrollee's cost only upon the  
2.19 addition to the formulary of a generic or multisource brand name drug rated as therapeutically  
2.20 equivalent according to the Food and Drug Administration (FDA) Orange Book or a biologic  
2.21 drug rated as interchangeable according to the FDA Purple Book at a lower cost to the  
2.22 enrollee and upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees.

2.23 (c) A health plan company may change utilization review requirements or move drugs  
2.24 to a benefit category that increases an enrollee's cost during the enrollee's contract term  
2.25 upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees, provided  
2.26 that these changes do not apply to enrollees who are currently taking the drugs affected by  
2.27 these changes for the duration of the enrollee's contract term.

2.28 (d) A health plan company may remove any drugs from its formulary that have been  
2.29 deemed unsafe by the FDA; that have been withdrawn by either the FDA or the product  
2.30 manufacturer; or when an independent source of research, clinical guidelines, or  
2.31 evidence-based standards has issued drug-specific warnings or recommended changes in  
2.32 drug usage.

3.1 Sec. 2. Minnesota Statutes 2018, section 256B.69, subdivision 6, is amended to read:

3.2 Subd. 6. **Service delivery.** (a) Each demonstration provider shall be responsible for the  
3.3 health care coordination for eligible individuals. Demonstration providers:

3.4 (1) shall authorize and arrange for the provision of all needed health services including  
3.5 but not limited to the full range of services listed in sections 256B.02, subdivision 8, and  
3.6 256B.0625 in order to ensure appropriate health care is delivered to enrollees.

3.7 Notwithstanding section 256B.0621, demonstration providers that provide nursing home  
3.8 and community-based services under this section shall provide relocation service coordination  
3.9 to enrolled persons age 65 and over;

3.10 (2) shall accept the prospective, per capita payment from the commissioner in return for  
3.11 the provision of comprehensive and coordinated health care services for eligible individuals  
3.12 enrolled in the program;

3.13 (3) may contract with other health care and social service practitioners to provide services  
3.14 to enrollees; and

3.15 (4) shall institute recipient grievance procedures according to the method established  
3.16 by the project, utilizing applicable requirements of chapter 62D. Disputes not resolved  
3.17 through this process shall be appealable to the commissioner as provided in subdivision 11.

3.18 (b) Demonstration providers must comply with the standards for claims settlement under  
3.19 section 72A.201, subdivisions 4, 5, 7, and 8, when contracting with other health care and  
3.20 social service practitioners to provide services to enrollees. A demonstration provider must  
3.21 pay a clean claim, as defined in Code of Federal Regulations, title 42, section 447.45(b),  
3.22 within 30 business days of the date of acceptance of the claim.

3.23 (c) Managed care plans and county-based purchasing plans must comply with section  
3.24 62Q.83.