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NINETY-FOURTH SESSION

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02/20/2025	434	Introduction and first reading Referred to Health and Human Services
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A bill for an act

relating to human services; requiring the commissioner of human services to select a state pharmacy benefit manager through procurement; requiring the commissioner of human services to enter into a master contract with the state pharmacy benefit manager; specifying program authority and eligibility requirements; requiring a report; amending Minnesota Statutes 2024, section 256B.69, subdivision 6d; proposing coding for new law in Minnesota Statutes, chapter 256B.

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

Section 1. Minnesota Statutes 2024, section 256B.69, subdivision 6d, is amended to read:

Subd. 6d. **Prescription drugs.** (a) The commissioner may exclude or modify coverage for prescription drugs from the prepaid managed care contracts entered into under this section in order to increase savings to the state by collecting additional prescription drug rebates.

(b) The contracts must maintain incentives for the managed care plan to manage drug costs and utilization and may require that the managed care plans maintain an open drug formulary. In order to manage drug costs and utilization, the contracts may authorize the managed care plans to use preferred drug lists and prior authorization. The contracts must conform with section 256B.696.

(c) This subdivision is contingent on federal approval of the managed care contract changes and the collection of additional prescription drug rebates.

Sec. 2. **[256B.696] PRESCRIPTION DRUGS; STATE PHARMACY BENEFIT MANAGER.**

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

(b) "Managed care plans" means health plans and county-based purchasing organizations providing coverage to medical assistance and MinnesotaCare enrollees under the managed care delivery system.

(c) "Managed care enrollees" means medical assistance and MinnesotaCare enrollees receiving coverage from managed care plans.

(d) "State pharmacy benefit manager" means the pharmacy benefit manager selected pursuant to the procurement process in subdivision 2.

Subd. 2. **Procurement process.** (a) The commissioner must, through a competitive procurement process in compliance with paragraph (b), select a single pharmacy benefit manager to comply with the requirements set forth in subdivision 3.

(b) The commissioner must, when selecting the single pharmacy benefit manager, do the following:

(1) accept applications for entities seeking to become the single pharmacy benefit manager;

(2) establish eligibility criteria an entity must meet in order to become the single pharmacy benefit manager; and

(3) enter into a master contract with a single pharmacy benefit manager.

(c) The contract required under paragraph (b), clause (3), must include a prohibition on the single pharmacy benefit manager from requiring an enrollee to obtain a specialty drug from a specialty pharmacy owned or otherwise affiliated with the single pharmacy benefit manager.

(d) Applicants for the single pharmacy benefit manager must disclose to the commissioner the following during the procurement process:

(1) any activity, policy, practice, contract, or arrangement of the single pharmacy benefit manager that may directly or indirectly present any conflict of interest with the pharmacy benefit manager's relationship with or obligation to the Department of Human Services, a health plan company, or county-based purchasing organization;

(2) all common ownership, members of a board of directors, managers, or other control of the pharmacy benefit manager or any of the pharmacy benefit manager's affiliated companies with (i) a health plan company or an affiliate of a health plan company, (ii) a county-based purchasing organization, (iii) an entity that contracts on behalf of a pharmacy or any pharmacy services administration organization and its affiliates, (iv) a drug wholesaler or distributor and its affiliates, (v) a third-party payer and its affiliates, or (vi) a pharmacy and its affiliates;

(3) any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in this state with which the pharmacy benefit manager shares common ownership, management, or control, or that are owned, managed, or controlled by any of the pharmacy benefit manager's affiliated companies;

(4) any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in this state; and

(5) any financial terms and arrangements between the pharmacy benefit manager and a prescription drug manufacturer or labeler, including formulary management, drug substitution programs, educational support claims processing, or data sales fees.

Subd. 3. **Drug coverage.** (a) The commissioner must approve or disapprove all utilization review limitations, requirements, and strategies imposed by managed care plans on prescription drug coverage.

(b) The commissioner must approve or disapprove all reimbursement rates, fees, and any other remuneration provided for drugs by managed care plans.

(c) The state pharmacy benefit manager is responsible for processing all pharmacy claims under the managed care delivery system. Managed care plans must use the state pharmacy benefit manager pursuant to the terms of the master contract required under subdivision 2, paragraph (b), clause (3). The pharmacy benefit manager selected is the exclusive pharmacy benefit manager used by health plan companies and county-based purchasing organizations when providing coverage to enrollees.

(d) All payment arrangements between the Department of Human Services, managed care plans, and the state pharmacy benefit manager must comply with state and federal statutes, regulations adopted by the Centers for Medicare and Medicaid Services, and any other agreement between the department and the Centers for Medicare and Medicaid Services. The commissioner may change a payment arrangement to comply with this paragraph.

(e) The commissioner must administer and oversee this section to:

(1) make prescription drugs available at the lowest possible cost to managed care enrollees;

(2) promote health through discounted prescription drugs and coordination of comprehensive prescription benefit services for managed care enrollees;

(3) ensure proper administration of prescription drug benefits for managed care enrollees; and

(4) increase the transparency of prescription drug prices and other information for the benefit of pharmacies.

Subd. 4. **Prescription drug disclosures.** (a) The state pharmacy benefit manager must, on request from the commissioner, disclose to the commissioner all sources of payment it receives for prescribed drugs, including any financial benefits including drug rebates, discounts, credits, clawbacks, fees, grants, chargebacks, reimbursements, or other payments related to services provided for a managed care plan.

(b) Each managed care plan must disclose to the commissioner, in the format specified by the commissioner, the entity's administrative costs associated with providing pharmacy services under the managed care delivery system.

(c) The state pharmacy benefit manager must provide a written quarterly report to the commissioner containing the following information from the immediately preceding quarter:

(1) the prices the state pharmacy benefit manager negotiated for prescribed drugs under the managed care delivery system. The price must include any rebates the state pharmacy benefit manager received from the drug manufacturer;

(2) the prices the state pharmacy benefit manager paid to pharmacies for prescribed drugs;

(3) any rebate amounts the state pharmacy benefit manager passed on to individual pharmacies;

(4) the percentage of savings in drug prices passed on to managed care enrollees;

(5) the information described in subdivision 2, paragraph (d); and

(6) any other information required by the commissioner.

(d) The commissioner may request and collect additional information and clinical data from the state pharmacy benefit manager.

(e) At the time of contract execution, renewal, or modification, the commissioner must modify the reporting requirements under its managed care contracts as necessary to meet the requirements of this subdivision.

Subd. 5. **Program authority.** (a) To accomplish the requirements of subdivision 3, paragraph (e), the commissioner, in consultation with the Formulary Committee established under section 256B.0625, subdivision 13c, has the authority to:

(1) adopt or develop a preferred drug list for managed care plans;

(2) at the commissioner's discretion, engage in price negotiations with prescription drug manufacturers, wholesalers, or group purchasing organizations in place of the state pharmacy benefit manager to obtain price discounts and rebates for prescription drugs for managed care enrollees; and

(3) develop and manage a drug formulary for managed care plans.

(b) The commissioner may contract with one or more entities to perform any of the functions described in paragraph (a).

Subd. 6. **Pharmacies.** The commissioner may review contracts between the state pharmacy benefit manager and pharmacies for compliance with this section and the master contract required under subdivision 2, paragraph (b), clause (3). The commissioner may amend any term or condition of a contract that does not comply with this section or the master contract.

Subd. 7. **Federal approval.** The commissioner must seek any necessary federal approvals to implement this section.

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.