SENATE COUNSEL, RESEARCH, & FISCAL ANALYSIS

BILL SUMMARY

S.F. No. 1876 (1st Engrossment) – Pharmacy benefit managers and health insurers inclusion of lower-cost drugs in formularies requirement provision and lowest out-of-pocket-cost drug to patient formulary tiering preference provision

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Bill Overview

S.F. 1876 requires pharmacy benefit managers (PBMs) and health insurers to add a brand name or generic drug to the health plan's formulary if the equivalent drug is already included on the formulary and has a higher wholesale acquisition cost (WAC). The bill applies this same requirement to both drugs and biologics. S.F. 1876 further requires PBMs and health insurers to add newly approved generic or biosimilar drugs to their formularies if those drugs have a lower WAC than an equivalent product currently on the formulary. Finally, the bill mandates that formularies and formulary tiers be structured to give preference to the drug that provides the lowest out-of-pocket cost to the patient. This legislation is effective January 1, 2026.

Section Summaries

Section 1 (adds Minn. Stat. § 62W.16; Inclusion of lower-cost drugs in formulary)

Subd. 1. Definitions. Defines key terms, including "biologic," "biosimilar," "brand name drug," "equivalent," "generic drug," "health plan," "out-of-pocket cost," and "wholesale acquisition cost."

Subd. 2. Brand name, generic, and biosimilar drugs; inclusion of lowest-cost drug in formulary. This subdivision requires a PBM or health carrier that includes a brand name drug on its formulary to also include an equivalent generic drug with a lower WAC, if one exists. It further mandates a PBM or health carrier that includes a generic drug on its formulary to also include the equivalent brand name drug with a lower WAC, if one exists. This subdivision applies the same requirements to brand name biologics and equivalent biosimilars.

Subd. 3. New generic and biosimilar drugs; inclusion of lowest-cost drug in formulary. This subdivision provides that, if the United States Food and Drug Administration approves a new generic drug with a lower WAC than the brand name drug in the formulary, the PBM or health insurer

must immediately make the newly approved generic available on its formulary. The subdivision also imposes parallel requirements for newly approved biosimilars that have a WAC lower than all equivalent biologics or biosimilars on the formulary.

Subd. 4. Formulary structure and tiering. This subdivision requires a PBM or health insurer to structure its formulary and formulary tiers so as to give the same preference to the drug (brand or generic) that offers the lowest out-of-pocket cost to the patient as the health plan does to equivalents on the formulary. Specifically, this subdivision prohibits the imposition of otherwise inapplicable prior authorization, step therapy, or other restrictions on that lowest-cost option. In addition, these same requirements are extended to brand name biologics and biosimilars, again prohibiting any utilization management that would additionally limit coverage of or access to the lowest-cost option.