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# **Evaluation of HF XXXX – Cost-Sharing Limitations for Epilepsy Medications and Supplies**

Report to the Minnesota Legislature Pursuant to Minn. Stat. § 62J. 26

02/11/2026

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Defrayal analysis completed by the Minnesota Department of Commerce is independent of AIR's evaluation.

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# Contents

- Executive Summary .....4
- Introduction .....4
- Bill Requirements .....5
- Related Health Conditions and Associated Services .....5
- Related State and Federal Laws .....6
  - Relevant Federal Laws .....6
  - Relevant Minnesota Laws .....6
  - State Comparison .....7
- Public Comments Summary .....8
  - Key Stakeholder Comment Themes .....8
  - Cost Estimates Provided in Stakeholder Comments .....8
- Actuarial Analysis .....9
  - Objective .....9
  - Assumptions and Approach .....9
  - Results ..... 10
  - Data Sources ..... 13
- State Fiscal Impact ..... 13
  - Fiscal Impact Estimate for SEGIP ..... 14
  - Affordable Care Act Mandate Impact and Analysis ..... 14
  - Fiscal Impact of State Public Programs ..... 14
- Appendix A. Bill Text ..... 15
- Appendix B. Associated Codes ..... 16
- Works Cited ..... 26

## Executive Summary

If enacted, this bill would limit health issuers' amount of enrollee cost-sharing for prescription drugs prescribed to treat epilepsy to no more than: (1) \$25 per one-month supply for each prescription drug, regardless of the amount or type of medication required to fill the prescription; and (2) \$50 per month in total for all related medical supplies. The cost-sharing limit for related medical supplies does not increase with the number of chronic diseases for which an enrollee is treated. Coverage under this section shall not be subject to any deductible.

There are no existing state or federal laws related to cost-sharing for epilepsy drugs and medical supplies. Federal laws, such as the Patient Protection and Affordable Care Act, cap drug costs for essential health benefits. Similarly, no other state has laws related to cost-sharing for epilepsy treatment, but six states have broader prescription drug cost limits that include epilepsy treatments. Minn. Stat. § 62Q.481 limits cost-sharing for prescription drugs and related medical supplies for any enrollee with a chronic disease to no more than \$25 per one-month supply of the drug and \$50 per month in total for all related medical supplies. If HF XXXX is passed, these same requirements will be applicable for epilepsy.

Public comments for this proposed mandate suggested that the bill language be revised to clarify what medications and supplies would be covered under the proposed mandate. Additionally, a respondent indicated a potential concern with the bill implementation as many drugs used to treat epilepsy are also prescribed for other conditions.

Estimated expenditures from the proposed mandate are projected to result in a net increase of \$0.04 per member per month (PMPM) for the non-publicly insured in the first year, increasing to \$0.05 PMPM by the tenth year.

The potential state fiscal impact of this mandate is as follows:

- Minnesota Management and Budget estimates the cost of this legislation for the State Employee Group Insurance Program to be \$12,000 for partial Fiscal Year 2027 (FY 2027) and \$25,200 for FY 2028.
- Commerce has determined that this proposed mandate would not require defrayal under the Affordable Care Act.
- This proposed mandate would apply to Minnesota Health Care Programs (e.g., Medical Assistance and MinnesotaCare).

## Introduction

In accordance with Minn. Stat. § 62J.26, the Minnesota Department of Commerce (Commerce), in consultation with the Minnesota Department of Health (MDH) and Minnesota Management and Budget (MMB), performs a detailed evaluation of all relevant benefit mandate proposals. For evaluation criteria and required evaluation

components, please review the Evaluation Report Methodology, available at <https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/>.

## Bill Requirements

This House bill is sponsored by Rep. Greene. At the time Commerce received the request for evaluation, the bill had not yet been introduced.

If enacted, this bill would limit health issuers' amount of enrollee cost-sharing for prescription drugs that treat epilepsy to no more than: (1) \$25 per one-month supply for each prescription drug, regardless of the amount or type of medication required to fill the prescription; and (2) \$50 per month in total for all related medical supplies. The cost-sharing limit for related medical supplies does not increase with the number of chronic diseases for which an enrollee is treated. Coverage under this section shall not be subject to any deductible.

For health plans that require an enrollee to meet a plan deductible in order to maintain health savings account eligibility under United States Code, title 26, section 223 or catastrophic health plan eligibility under United States Code, title 42, section 18022(e), this proposed mandate would apply only after the deductible has been met.

This proposed mandate would apply to fully insured small and large group commercial health plans, individual market plans, Minnesota Health Care Programs (e.g., Medical Assistance and MinnesotaCare), and the State Employee Group Insurance Program (SEGIP). This would not apply to self-insured employer plans, grandfathered plans, or Medicare supplemental policies.

This bill would amend Minnesota Statutes 2024, section 62Q.481, subdivision 2.

## Related Health Conditions and Associated Services

Epilepsy is a chronic brain disorder where groups of nerve cells, or neurons, in the brain may misfire, causing seizures.<sup>1</sup> There are many types of seizures, with some individuals experiencing convulsions and loss of consciousness (e.g., tonic-clonic seizures) while others cause a person to appear as if they are staring into space for extended periods of time (e.g., absence seizures). Epilepsy can vary in severity and frequency of seizures. Having a seizure does not mean an individual has epilepsy. There are several types of epilepsy, including but not limited to:<sup>1</sup>

- Absence epilepsy;
- Frontal lobe epilepsy;
- Temporal lobe epilepsy; and
- Neocortical epilepsy.

The cause of epilepsy is not always known, but it can occur with a range of other conditions that disrupt normal brain activity, known as co-occurring conditions. These may include, but are not limited to:<sup>1</sup>

- Brain tumors;
- Head trauma;
- Stroke;

- Cerebral palsy and other developmental disorders; and
- Infections (e.g., meningitis).

Antiseizure prescription medications used to treat epilepsy are generally categorized into two groups: broad-spectrum and narrow-spectrum. Broad-spectrum medications (e.g., levetiracetam, lamotrigine, zonisamide, and topiramate) treat various seizure types, while narrow-spectrum medications (e.g., ethosuximide, pregabalin, gabapentin, and carbamazepine) target focal or partial seizures.<sup>2</sup>

This proposed mandate would require coverage for all medical supplies used to treat epilepsy, such as United States Food and Drug Administration (FDA)-approved seizure detection devices.<sup>3</sup>

## Related State and Federal Laws

This section provides an overview of state and federal laws related to the proposed mandate and any external factors that provide context on current policy trends related to this topic.

### Relevant Federal Laws

Federal laws do not specifically set cost-sharing limits for epilepsy drugs and supplies. Instead, they establish broader out-of-pocket (OOP) spending caps for prescription drugs and medical supplies, which may include epilepsy treatments. The [Patient Protection and Affordable Care Act \(ACA\)](#) mandates OOP maximums for all non-grandfathered group/individual plans offered both on and off the Marketplace covering essential health benefits (EHBs), including prescription drugs. Additionally, health plans that cover EHBs must allow enrollees to request and gain access to clinically appropriate drugs not otherwise covered by a health plan, which may include epilepsy treatments.<sup>4</sup> The OOP maximums for EHB plans in 2026 are \$10,600 for an individual and \$21,200 for a family, and increase to \$12,000 for an individual and \$24,000 for a family in 2027.<sup>5</sup> Chronic disease management is included as an EHB, so the OOP maximum includes related medical supplies needed to treat epilepsy. However, the ACA does not specify cost-sharing requirements related to chronic disease management.<sup>4</sup> [H.R. 2553](#) was proposed in April 2025 and would cap prescription drug cost-sharing under the ACA at \$2,000 per individual and \$4,000 per family per year, starting in 2026.<sup>6</sup>

Starting in 2024, the [Inflation Reduction Act](#) mandates that Medicare enrollees no longer pay cost-sharing once they reach the annual OOP limit. Beginning in 2025, that limit was capped at \$2,000.<sup>7</sup> In 2026, the OOP limit increased to \$2,100 to reflect the rise in average 2025 expenditures for covered part D drugs, including epilepsy treatments.<sup>8</sup>

### Relevant Minnesota Laws

Minnesota has existing laws that provide healthcare coverage for chronic diseases, including epilepsy treatment and related medical devices, but the proposed mandate would expand and standardize these requirements by explicitly incorporating epilepsy care into chronic disease coverage. [Minn. Stat. § 62Q.81, subd. 4](#), requires coverage of chronic disease managements as an EHB, but it does not cover cost-sharing for prescription drugs and related medical supplies prescribed to treat a chronic disease.<sup>9</sup>

Minnesota passed [Minn. Stat. § 62Q.481](#) to address cost-sharing limits for prescription drugs and related medical supplies. It sets cost-sharing limits of prescription drugs for any enrollee with a chronic disease to no

more than \$25 per one-month supply of the drug and \$50 per month in total for all related medical supplies.<sup>10</sup> The proposed mandate modifies this statute to include epilepsy in the definition of “chronic disease.” In 2024, Minnesota established a Prescription Drug Affordability Board (PDAB) through [Minn. Stat. § 62J.87](#) that protects consumers from high costs of prescription drugs, including those for epilepsy, by reviewing drug prices and setting upper payment limits.<sup>11</sup>

Minnesota is the first state to require Medicaid to cover FDA-approved seizure detection devices through [Minn. Stat. 2022 § 256B.0625, subd. 31](#), which determines that seizure detection devices are covered as durable medical equipment (DME). They define “seizure detection devices” as an FDA-approved monitoring device, including technology that continuously monitors patients for seizures, sends alerts to caregivers for timely medical response, and collects seizure data for healthcare providers to support diagnosis and treatment. Coverage includes wearable seizure monitors and other devices that help prevent Sudden Unexpected Deaths in Epilepsy (SUDEP).<sup>12</sup>

[SF 1538/HF 1765](#) was proposed in February 2025 and would create the Minnesota Epilepsy Program. If passed, this program would provide statewide epilepsy support and education services, train healthcare workers and educators, and collect epilepsy data for a better understanding of its prevalence and scope.<sup>13</sup>

## State Comparison

While no state has mandated cost-sharing limits specific to epilepsy, six states have implemented broader prescription drug cost limits that include epilepsy treatments. These states impose cost-sharing caps ranging from \$150 per month to \$3,500 per year. The type of coverage varies by state, with some states covering outpatient prescription drugs and others covering specialty tier drugs only.<sup>14–19</sup>

Some states have implemented other approaches to limit out of pocket spending on drugs. Vermont caps hospital-administered outpatient prescription drug charges at 120% of the Average Sales Price (ASP), as set by the Centers for Medicare and Medicaid Services (CMS).<sup>19</sup> Delaware enacted a law that requires insurers to count third party assistance towards deductibles in cost-sharing calculations, which helps reduce patient OOP expenses compared to calculations that exclude such assistance.<sup>17</sup> Maryland passed a law that empowers their PDAB to set upper payment limits for purchases and reimbursements of prescription drug products that the Board determines have led to affordability challenges.<sup>14</sup>

**Table 1. States With Laws on Prescription Drug Cost-Sharing Limits**

State	Covered Drugs	Cost-Sharing Limits	Notes
CA <sup>15</sup>	All outpatient prescription drugs	\$250/month	\$500 for Bronze-tier plans
DE <sup>17</sup>	All prescription drugs	N/A	Cannot exceed retail or contract price; coupons must count toward OOP
LA <sup>16</sup>	Specialty-tier drugs	\$150/month	Includes formulary exception process
MD <sup>14</sup>	Specialty drugs; high-cost drugs	\$150/month	Co-pay is less than retail price; PDAB may set price caps
ME <sup>18</sup>	Prescription drugs with coinsurance	\$3,500/year	Separate prescription OOP cap if not included in total plan OOP
VT <sup>19</sup>	Hospital-administered drugs	120% of ASP	Limits what hospitals can bill insurers

## Public Comments Summary

Commerce solicited public input on the potential health benefit mandate through a request for information (RFI) posted to Commerce’s website and the Minnesota State Register. The summary below represents only the opinions and input of the organizations who responded to the RFI.

### Key Stakeholder Comment Themes

For this proposed mandate, Commerce received RFI responses from three commercial health issuers.

**Clarity of Bill Language.** Multiple respondents suggested that the bill language be revised to clarify which epilepsy-related devices and treatments would be covered under the proposed mandate. One respondent indicated it is not clear which types of medical supplies or DME could be subject to the requirements of this bill, including any coverage implications for seizure detection devices approved by the FDA.

**Implementation Concerns.** One respondent indicated potential concerns related to implementation of the bill, noting that many drugs used for epilepsy are also prescribed for other conditions or off-label indications and, unless prior authorization is applied, there would be no reliable mechanism to identify a member’s epilepsy diagnosis at the point of dispensing. One respondent suggested that a low monthly limit on co-pays could present fraud, waste, and abuse risks.

### Cost Estimates Provided in Stakeholder Comments

Stakeholders and MMB provided the following cost estimates related to the proposed benefit mandate:

- MMB’s health plan administrators estimated the average state fiscal impact of the proposed mandate to be \$0.02 per member per month (PMPM), as the bill would classify epilepsy as a chronic disease, limiting cost-sharing for epilepsy medications and supplies (see [State Fiscal Impact section](#)).
- Two respondents noted that if this mandate were enacted, it would expect increased costs for commercial health plan coverage. One respondent estimated a cost increase of up to \$0.35 PMPM while another respondent did not provide a specific estimate. A third respondent indicated it would not expect a cost impact but noted that DME was not considered for the analysis.

Stakeholders’ results may or may not reflect generalizable estimates for this mandate, depending on the methodology, data sources, and assumptions used for analysis.

## Evaluation of Proposed Health Benefit Mandate

### Methodology

The following section includes the actuarial analysis performed to examine the potential economic impact of the mandate. For further information on the literature review methodology, please reference <https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/>.

## Actuarial Analysis<sup>a</sup>

### Objective

This actuarial analysis evaluates the current prevalence of diagnoses, utilization, and cost-sharing for epilepsy related prescription drugs and related medical supplies, as well as the proposed mandate's potential effects on overall expenditures due to a cap on enrollee cost-sharing.

### Assumptions and Approach

MDH provided Actuarial Research Corporation (ARC) with tabulations from the Minnesota All Payer Claims Database (MN APCD) of all diagnoses and prescription drugs relating to epilepsy and seizure disorders for Minnesota commercial health plan enrollees over a historical period spanning 2021-2024.<sup>20</sup> Per MDH, the MN APCD includes approximately 40% of the total commercial market in Minnesota.<sup>21</sup>

Enrollees were identified as having an epilepsy or seizure disorder diagnosis if they had one of the International Classification of Diseases, Tenth Revision (ICD-10) diagnosis codes in [Appendix B](#). The 2021-2024 number of enrollees utilizing prescription drugs for epilepsy as well as the enrollee cost-sharing amounts, with an additional tabulation for OOP enrollee expenditures exceeding \$25 in a given month, were tabulated by MDH. The proposed mandate limits enrollee cost-sharing for prescription drugs to no more than \$25.

Enrollees were identified as having utilized epilepsy related prescription drugs if they had one of the National Drug Codes (NDC) in [Appendix B](#). Enrollees were identified as having received an epilepsy medical supply if they had one of the Healthcare Common Procedure Coding System (HCPCS) codes in [Appendix B](#). However, for the epilepsy related medical supplies identified for this analysis, the total statewide utilization in each year was below the threshold required for reporting so they were not included in this analysis.

The 2021-2024 epilepsy or seizure disorder diagnosis prevalence, as tabulated by MDH, was 0.57% for the full commercial population included in the MN APCD. The proportion of diagnosed enrollees utilizing drugs in treatment of epilepsy was 67%. For epilepsy prescription drug utilization and increased adherence, 2015 and 2017 National Health Interview Surveys found that among adults with active epilepsy, 13.2% reported inability to afford prescription medicine, 9.3% reported skipping medication doses to save money, 12.2% reported delaying refills, and 10.8% reported taking less than the prescribed dosages of medicine to save money.<sup>22</sup>

This mandate is proposed to be enacted as an amendment to [Minn. Stat. § 62Q.481](#), capping the total cost-sharing for the chronic conditions of diabetes, asthma, and allergies requiring the use of epinephrine auto-injectors. Without a more comprehensive analysis of the co-occurrence of epilepsy with those other chronic conditions in Minnesota, this actuarial analysis considers solely epilepsy and seizure disorders.

The overall Minnesota population projections are based on the figures published by the Minnesota State Demographic Center.<sup>23</sup> Given the historic non-public health insurance coverage levels from Minnesota Public

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<sup>a</sup> Michael Sandler and Anthony Simms are actuaries for Actuarial Research Corporation (ARC). They are members of the American Academy of Actuaries and meet the qualification standards of the American Academy of Actuaries to render the actuarial opinions contained herein.

Health Data Access, 65% of the total state population under the age of 65 were assumed to be included in the non-publicly insured population.<sup>24</sup>

## Results

This analysis projects epilepsy and seizure disorder prevalence in Minnesota for the total non-publicly insured population as well as current law utilization and cost-sharing for epilepsy related prescription drugs, then projects potential utilization and cost-sharing under the mandate's cap on enrollee cost-sharing. Table 2 shows projected epilepsy and seizure disorder prevalence and projected prescription drug utilization, and cost-sharing based on historic claims and current law. Table 3 shows projected epilepsy and seizure disorder prevalence and projected prescription drug utilization, cost-sharing, and increased plan expenditures under the proposed mandate.

**Table 2. Total Projected Epilepsy Diagnosis Prevalence and Utilization Under Current Law and Projected Under Proposed Mandate<sup>b</sup>**

	Population		Prevalence	Current Law Utilization			Projected Total Utilization		
	Total Minnesota Population	Non-Publicly Insured Population	Diagnoses of Epilepsy or Seizure Disorders	Enrollees	Member Months	Thirty Day Equivalents	Enrollees	Member Months	Thirty Day Equivalents
2027	5,854,785	3,064,627	17,468	11,704	67,882	157,486	13,625	79,027	183,342
2028	5,878,663	3,070,240	17,500	11,725	68,006	157,775	13,650	79,172	183,678
2029	5,901,603	3,075,295	17,529	11,745	68,118	158,035	13,673	79,302	183,981
2030	5,923,535	3,079,734	17,554	11,762	68,217	158,263	13,692	79,416	184,246
2031	5,944,374	3,083,514	17,576	11,776	68,300	158,457	13,709	79,514	184,472
2032	5,964,016	3,086,623	17,594	11,788	68,369	158,617	13,723	79,594	184,658
2033	5,982,648	3,095,934	17,647	11,823	68,576	159,095	13,765	79,834	185,215
2034	6,000,234	3,104,721	17,697	11,857	68,770	159,547	13,804	80,061	185,741
2035	6,016,749	3,112,910	17,744	11,888	68,952	159,968	13,840	80,272	186,231
2036	6,032,169	3,120,531	17,787	11,917	69,120	160,359	13,874	80,469	186,687

<sup>b</sup> The state health benefit mandates generally only apply to fully insured individual, small group, and large group health plans regulated in Minnesota, except where explicitly indicated. Prevalence, utilization, and expenditures were scaled to the entire non-publicly insured market in Minnesota for illustrative purposes. For more details, see the *Assumptions and Approach* section.

**Table 3. Total Projected Epilepsy-Related Prevalence and Expenditures Under Proposed Mandate<sup>c</sup>**

	Population		Projected Total Utilization			Expenditures				
	Total Minnesota Population	Non-Publicly Insured Population	Enrollees	Member Months	Thirty Day Equivalent	Total Rx PMPM: Plan + Cost-sharing	Current Law Cost-sharing PMPM	Out-of-Pocket PMPM > \$25	Projected Current Law Cost-share Expenditures Exceeding Threshold	Total Non-Publicly Insured PMPM Change
2027	5,854,785	3,064,627	13,625	79,027	183,342	\$331.08	\$44.71	\$17.35	\$1,370,832	\$0.04
2028	5,878,663	3,070,240	13,650	79,172	183,678	\$343.00	\$46.32	\$17.84	\$1,412,443	\$0.04
2029	5,901,603	3,075,295	13,673	79,302	183,981	\$357.06	\$48.22	\$18.33	\$1,453,262	\$0.04
2030	5,923,535	3,079,734	13,692	79,416	184,246	\$372.77	\$50.34	\$18.82	\$1,494,412	\$0.04
2031	5,944,374	3,083,514	13,709	79,514	184,472	\$386.93	\$52.26	\$19.42	\$1,543,880	\$0.04
2032	5,964,016	3,086,623	13,723	79,594	184,658	\$402.41	\$54.35	\$20.07	\$1,597,165	\$0.04
2033	5,982,648	3,095,934	13,765	79,834	185,215	\$420.92	\$56.85	\$20.84	\$1,663,421	\$0.04
2034	6,000,234	3,104,721	13,804	80,061	185,741	\$440.28	\$59.46	\$21.64	\$1,732,118	\$0.05
2035	6,016,749	3,112,910	13,840	80,272	186,231	\$460.54	\$62.20	\$22.46	\$1,803,291	\$0.05
2036	6,032,169	3,120,531	13,874	80,469	186,687	\$481.72	\$65.06	\$23.33	\$1,877,033	\$0.05

<sup>c</sup> The state health benefit mandates generally only apply to fully insured individual, small group, and large group health plans regulated in Minnesota, except where explicitly indicated. Prevalence, utilization, and expenditures were scaled to the entire non-publicly insured market in Minnesota for illustrative purposes. This does not impact PMPM estimates. For more details, see the *Assumptions and Approach* section.

The total statewide non-publicly insured population expenditures for epilepsy prescription drugs that would be paid by the plan under the proposed mandate (and would have been paid OOP by the enrollee under current law) are projected to be \$1.37 million in year one, increasing to \$1.88 million in the tenth and final year of the projection period. Overall, the mandate is projected to result in a net increase of \$0.04 PMPM for the total non-publicly insured in year one of the projection, and that will increase to \$0.05 PMPM in the tenth and final year of the projection.

A more comprehensive actuarial analysis and modeling of all epilepsy related expenditures, including downstream effects of prescription drug adherence/non-adherence, and a full picture of what current coverage and expenditures are for Minnesota was not feasible with the available data.

The actuarial analysis consulted relevant, available literature to assess the broader environment of coverage, utilization, and expenditures and explore avenues of potential long-term savings and improved health outcomes. When looking at health plan OOP costs for antiepileptic drugs and overall healthcare utilization and plan spending among United States-based commercial health plan enrollees with epilepsy, there is a negative correlation between OOP spending and overall healthcare utilization.<sup>25</sup> Additionally, non-adherent patients have a significantly higher rate of poor seizure control and recurrent seizures leading to emergency room visits compared to their adherent counterparts.<sup>26</sup>

## Data Sources

- Minnesota state population projections are from the “Long-Term Population Projections for Minnesota” published by the Minnesota State Demographic Center.<sup>23</sup>
- Minnesota non-public health insurance coverage levels are from Minnesota Public Health Data Access.<sup>24</sup>
- Trends and projection factors are derived from the National Health Expenditure data.<sup>27</sup>
- MDH tabulations of the MN APCD from 2021 to 2024 were used for the estimation of epilepsy and seizure disorder diagnosis prevalence and historical utilization, expenditures, and enrollee cost-sharing for epilepsy prescription drugs.<sup>20</sup>

## State Fiscal Impact

The potential state fiscal impact of this legislation includes the estimated cost to SEGIP as assessed by MMB in consultation with health plan administrators, the cost of defrayal of benefit mandates as understood under the ACA, and the estimated cost to Minnesota Health Care Programs.

- Minnesota Management and Budget (MMB) estimates the cost of this legislation for SEGIP to be \$12,000 for partial Fiscal Year 2027 (FY 2027) and \$25,200 for FY 2028.
- Commerce has determined that this proposed mandate would not require defrayal under the ACA.
- This proposed mandate would apply to Minnesota Health Care Programs (e.g., Medical Assistance and MinnesotaCare).

## **Fiscal Impact Estimate for SEGIP**

MMB provided SEGIP's fiscal impact analysis, which is based on current antiseizure medication utilization and current preferred and non-preferred drug co-pay levels. MMB's analysis predicted a PMPM fiscal impact of \$0.02 PMPM. MMB noted that the Advantage Plan currently provides coverage without prior authorization for antiseizure medications with \$30 and \$55 co-pays for one-month supplies of preferred and non-preferred drugs, respectively. Additionally, there is currently coverage for FDA-approved seizure detection devices and related remote patient monitoring by a provider, but at cost-sharing rates which exceed the proposed mandates cap on related medical supplies. However, due to low utilization rates, the fiscal impact from the related medical supplies would be negligible. The partial fiscal year impact of the proposed legislation on SEGIP is estimated to be \$12,000 for partial FY 2027 (\$0.02 PMPM medical cost x 133,000 members x 6 months). The estimated impact for FY 2028 equals \$25,200, and the amount is estimated to increase by 5% annual inflation factor each of the following years due to the increasing cost of medical services.

## **Affordable Care Act Mandate Impact and Analysis**

States may require qualified health plan issuers to cover benefits in addition to the 10 EHBs defined by the ACA but must defray the costs, either through payments to individual enrollees or directly to issuers, and can partially defray the costs of proposed mandates if some of the care, treatment, or services are already covered in the state's benchmark plan or mandated by federal law, pursuant to section 1311(d)(3)(b) of the ACA. For further defrayal requirements and methodology, please visit <https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/>.

If enacted, Commerce assumes this bill would not constitute an additional benefit mandate, as it does not relate to any new requirements for specific care, treatment, or services that are not already covered by Minnesota's EHB Benchmark Plan. The Minnesota EHB Benchmark Plan includes coverage for prescription drugs such as anticonvulsants, DME, and habilitation services. The proposed mandate only alters cost-sharing associated with required coverage.

## **Fiscal Impact of State Public Programs**

This proposed mandate would apply to Minnesota Health Care Programs (e.g., Medical Assistance and MinnesotaCare) as Minn. Stat. § 256L.03, subd. 5, paragraph (d) requires that cost-sharing for prescription drugs and related medical supplies to treat chronic diseases must comply with the requirements of Minn. Stat. § 62Q.481. Currently, the maximum cost-sharing in MinnesotaCare for a prescription is \$25 for a brand name drug. Existing MinnesotaCare co-payments cannot increase beyond their current levels, and cost-sharing amounts may need to change for other services (e.g., generic drugs) in order to comply with the requirements of this mandate. There is currently no cost-sharing in Medical Assistance. However, a fiscal estimate has not yet been completed on this proposed mandate.

## Appendix A. Bill Text

Section 1. Minnesota Statutes 2024, section 62Q.481, subdivision 2, is amended to read:

Subd. 2. **Definitions.**

(a) For purposes of this section, the following definitions apply.

(b) "Chronic disease" means diabetes, asthma, epilepsy, and allergies requiring the use of epinephrine auto-injectors.

(c) "Cost-sharing" means co-payments and coinsurance.

(d) "Related medical supplies" means syringes, insulin pens, insulin pumps, test strips, glucometers, continuous glucose monitors, epinephrine auto-injectors, asthma inhalers, and other medical supply items necessary to effectively and appropriately treat a chronic disease or administer a prescription drug prescribed to treat a chronic disease.

**EFFECTIVE DATE.** This section is effective January 1, 2027, and applies to health plans offered, issued, or renewed on or after that date.

## Appendix B. Associated Codes

### Epilepsy Procedure Codes

Name	Code
<b>ICD-10 Procedure Codes</b>	
Epilepsy and recurrent seizures	G40.XX
Status epilepticus	G41.XX
<b>HCPCS Codes</b>	
Monitoring feature/device, stand-alone or integrated, any type, includes all accessories, components, and electronics, not otherwise classified	A9279
Remote monitoring of physiologic parameters, initial supply of devices with daily recordings or programmed alerts transmission, each 30 days	99454
<b>NDC Codes</b>	
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