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State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FOURTH SESSION

H. F. No. 4609

03/23/2026 Authored by Kotyza-Witthuhn, Pérez-Vega, Acomb, Rehrauer, Agbaje and others
The bill was read for the first time and referred to the Committee on Health Finance and Policy

1.1 A bill for an act
1.2 relating to health; requiring health plans to cover infertility treatment and standard
1.3 fertility preservation services; requiring medical assistance and MinnesotaCare to
1.4 cover infertility treatment and standard fertility preservation services; appropriating
1.5 money; amending Minnesota Statutes 2024, sections 62Q.679; 256B.0625, by
1.6 adding a subdivision; Minnesota Statutes 2025 Supplement, section 256B.0625,
1.7 subdivision 13; proposing coding for new law in Minnesota Statutes, chapter 62Q.

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

1.9 Section 1. 62Q.60 **COVERAGE OF INFERTILITY TREATMENT.**

1.10 Subdivision 1. Scope. This section applies to all health plans that provide maternity
1.11 benefits to Minnesota residents.

1.12 Subd. 2. Definitions. (a) For purposes of this section, the following terms have the
1.13 meanings given.

1.14 (b) "Diagnosis of and treatment for infertility" means procedures and medications:

1.15 (1) used to diagnose or treat infertility; and

1.16 (2) consistent with established, published, or approved medical practices or professional
1.17 guidelines from the American College of Obstetricians and Gynecologists or the American
1.18 Society for Reproductive Medicine.

1.19 (c) "Infertility" means a disease, condition, or status characterized by:

1.20 (1) the failure of a person with a uterus to establish a pregnancy or to carry a pregnancy
1.21 to live birth after the following duration of unprotected sexual intercourse, regardless of
1.22 whether a pregnancy resulted in miscarriage during that time:

2.1 (i) for a person under the age of 35, 12 months' duration; or

2.2 (ii) for a person 35 years of age or older, six months' duration;

2.3 (2) a person's inability to reproduce without medical intervention either as a single  
 2.4 individual or with the person's partner; or

2.5 (3) a licensed health care provider's determination that a patient is infertile based on the  
 2.6 patient's medical, sexual, and reproductive history; age; physical findings; or diagnostic  
 2.7 testing.

2.8 (d) "Standard fertility preservation services" means procedures that are consistent with  
 2.9 the established medical practices or professional guidelines published by the American  
 2.10 Society for Reproductive Medicine or the American Society of Clinical Oncology for a  
 2.11 person who has a medical condition or is expected to undergo medication therapy, surgery,  
 2.12 radiation, chemotherapy, or other medical treatment that is recognized by medical  
 2.13 professionals to cause a risk of impairment to fertility.

2.14 Subd. 3. **Required coverage.** (a) Health plans must provide comprehensive coverage  
 2.15 for:

2.16 (1) the diagnosis of and treatment for infertility; and

2.17 (2) standard fertility preservation services.

2.18 (b) Coverage under this section must include unlimited embryo transfers, but may impose  
 2.19 a limit of four completed oocyte retrievals. Single embryo transfer must be used when  
 2.20 medically appropriate and recommended by the treating health care provider.

2.21 (c) Coverage for surgical reversal of elective sterilization is not required under this  
 2.22 section.

2.23 Subd. 4. **Cost-sharing requirements.** A health plan must not impose any cost-sharing  
 2.24 requirement on the coverage under this section that is greater than the cost-sharing  
 2.25 requirement imposed on maternity coverage under the plan, including but not limited to the  
 2.26 following requirements:

2.27 (1) co-payment;

2.28 (2) deductible; or

2.29 (3) coinsurance.

2.30 Subd. 5. **Exclusions and limitations.** (a) A health plan must not impose any benefit  
 2.31 maximum, waiting period, utilization review, referral requirement, or any other limitation

3.1 on the coverage under this section, except as provided in subdivision 3, paragraphs (b) and  
 3.2 (c), that is not generally applicable to maternity coverage under the health plan.

3.3 (b) The prohibition under this subdivision includes but is not limited to any exclusion,  
 3.4 limitation, or other restriction on:

3.5 (1) fertility medications that are different from those imposed on other prescription  
 3.6 medications; and

3.7 (2) any fertility services based on an enrollee's participation in fertility services provided  
 3.8 by or to a third party.

3.9 Subd. 6. **Reimbursement.** (a) The commissioner of commerce must reimburse health  
 3.10 plan companies for coverage under this section. Reimbursement is available only for coverage  
 3.11 that would not have been provided by the health plan without the requirements of this  
 3.12 section. Treatments and services covered by the health plan as of January 1, 2026, are  
 3.13 ineligible for payment under this subdivision by the commissioner of commerce.

3.14 (b) Health plan companies must report to the commissioner of commerce quantified  
 3.15 costs attributable to the additional benefit under this section in a format developed by the  
 3.16 commissioner. A health plan's coverage as of January 1, 2026, must be used by the health  
 3.17 plan company as the basis for determining whether coverage would not have been provided  
 3.18 by the health plan for purposes of this subdivision.

3.19 (c) The commissioner of commerce must evaluate submissions and make payments to  
 3.20 health plan companies as provided in Code of Federal Regulations, title 45, section 155.170.

3.21 Subd. 7. **Appropriation.** Beginning in fiscal year 2028, an amount necessary to make  
 3.22 payments to health plan companies to defray the cost of providing coverage under this  
 3.23 section is annually appropriated from the general fund to the commissioner of commerce.  
 3.24 The amount appropriated under this subdivision must include the administrative costs  
 3.25 incurred by the commissioner to make the defrayal payments.

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

3.28 Sec. 2. Minnesota Statutes 2024, section 62Q.679, is amended to read:

3.29 **62Q.679 RELIGIOUS OBJECTIONS.**

3.30 Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

3.31 (b) "Closely held for-profit entity" means an entity that is not a nonprofit entity, has  
 3.32 more than 50 percent of the value of its ownership interest owned directly or indirectly by

4.1 five or fewer owners, and has no publicly traded ownership interest. For purposes of this  
4.2 paragraph:

4.3 (1) ownership interests owned by a corporation, partnership, limited liability company,  
4.4 estate, trust, or similar entity are considered owned by that entity's shareholders, partners,  
4.5 members, or beneficiaries in proportion to their interest held in the corporation, partnership,  
4.6 limited liability company, estate, trust, or similar entity;

4.7 (2) ownership interests owned by a nonprofit entity are considered owned by a single  
4.8 owner;

4.9 (3) ownership interests owned by all individuals in a family are considered held by a  
4.10 single owner. For purposes of this clause, "family" means brothers and sisters, including  
4.11 half-brothers and half-sisters, a spouse, ancestors, and lineal descendants; and

4.12 (4) if an individual or entity holds an option, warrant, or similar right to purchase an  
4.13 ownership interest, the individual or entity is considered to be the owner of those ownership  
4.14 interests.

4.15 (c) "Eligible organization" means an organization that opposes covering some or all  
4.16 health benefits under section 62Q.522, 62Q.524, ~~or 62Q.585~~, or 62Q.60 on account of  
4.17 religious objections and that is:

4.18 (1) organized as a nonprofit entity and holds itself out to be religious; or

4.19 (2) organized and operates as a closely held for-profit entity, and the organization's  
4.20 owners or highest governing body has adopted, under the organization's applicable rules of  
4.21 governance and consistent with state law, a resolution or similar action establishing that the  
4.22 organization objects to covering some or all health benefits under section 62Q.522, 62Q.524,  
4.23 ~~or 62Q.585~~, or 62Q.60 on account of the owners' sincerely held religious beliefs.

4.24 (d) "Exempt organization" means an organization that is organized and operates as a  
4.25 nonprofit entity and meets the requirements of section 6033(a)(3)(A)(i) or (iii) of the Internal  
4.26 Revenue Code of 1986, as amended.

4.27 Subd. 2. **Exemption.** (a) An exempt organization is not required to provide coverage  
4.28 under section 62Q.522, 62Q.524, ~~or 62Q.585~~, or 62Q.60 if the exempt organization has  
4.29 religious objections to the coverage. An exempt organization that chooses to not provide  
4.30 coverage pursuant to this paragraph must notify employees as part of the hiring process and  
4.31 must notify all employees at least 30 days before:

4.32 (1) an employee enrolls in the health plan; or

5.1 (2) the effective date of the health plan, whichever occurs first.

5.2 (b) If the exempt organization provides partial coverage under section 62Q.522, 62Q.524,  
5.3 ~~or 62Q.585, or 62Q.60~~, the notice required under paragraph (a) must provide a list of the  
5.4 portions of such coverage which the organization refuses to cover.

5.5 Subd. 3. **Accommodation for eligible organizations.** (a) A health plan established or  
5.6 maintained by an eligible organization complies with the coverage requirements of section  
5.7 62Q.522, 62Q.524, ~~or 62Q.585, or 62Q.60~~, with respect to the health benefits identified in  
5.8 the notice under this paragraph, if the eligible organization provides notice to any health  
5.9 plan company with which the eligible organization contracts that it is an eligible organization  
5.10 and that the eligible organization has a religious objection to coverage for all or a subset of  
5.11 the health benefits under section 62Q.522, 62Q.524, ~~or 62Q.585, or 62Q.60~~.

5.12 (b) The notice from an eligible organization to a health plan company under paragraph  
5.13 (a) must include: (1) the name of the eligible organization; (2) a statement that it objects to  
5.14 coverage for some or all of the health benefits under section 62Q.522, 62Q.524, ~~or 62Q.585,~~  
5.15 or 62Q.60, including a list of the health benefits to which the eligible organization objects,  
5.16 if applicable; and (3) the health plan name. The notice must be executed by a person  
5.17 authorized to provide notice on behalf of the eligible organization.

5.18 (c) An eligible organization must provide a copy of the notice under paragraph (a) to  
5.19 prospective employees as part of the hiring process and to all employees at least 30 days  
5.20 before:

5.21 (1) an employee enrolls in the health plan; or

5.22 (2) the effective date of the health plan, whichever occurs first.

5.23 (d) A health plan company that receives a copy of the notice under paragraph (a) with  
5.24 respect to a health plan established or maintained by an eligible organization must, for all  
5.25 future enrollments in the health plan:

5.26 (1) expressly exclude coverage for those health benefits identified in the notice under  
5.27 paragraph (a) from the health plan; and

5.28 (2) provide separate payments for any health benefits required to be covered under  
5.29 section 62Q.522, 62Q.524, ~~or 62Q.585, or 62Q.60~~ for enrollees as long as the enrollee  
5.30 remains enrolled in the health plan.

5.31 (e) The health plan company must not impose any cost-sharing requirements, including  
5.32 co-pays, deductibles, or coinsurance, or directly or indirectly impose any premium, fee, or  
5.33 other charge for the health benefits under section 62Q.522 on the enrollee. The health plan

6.1 company must not directly or indirectly impose any premium, fee, or other charge for the  
6.2 health benefits under section 62Q.522, 62Q.524, ~~or 62Q.585~~, or 62Q.60 on the eligible  
6.3 organization or health plan.

6.4 (f) On January 1, 2025, and every year thereafter a health plan company must notify the  
6.5 commissioner, in a manner determined by the commissioner, of the number of eligible  
6.6 organizations granted an accommodation under this subdivision.

6.7 **EFFECTIVE DATE.** This section is effective January 1, 2027.

6.8 Sec. 3. Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 13, is  
6.9 amended to read:

6.10 Subd. 13. **Drugs.** (a) Medical assistance covers drugs, ~~except for fertility drugs when~~  
6.11 ~~specifically used to enhance fertility~~, if prescribed by a licensed practitioner and dispensed  
6.12 by a licensed pharmacist, by a physician enrolled in the medical assistance program as a  
6.13 dispensing physician, or by a physician, a physician assistant, or an advanced practice  
6.14 registered nurse employed by or under contract with a community health board as defined  
6.15 in section 145A.02, subdivision 5, for the purposes of communicable disease control.

6.16 (b) The dispensed quantity of a prescription drug must not exceed a 34-day supply unless  
6.17 authorized by the commissioner or as provided in paragraph (h) or the drug appears on the  
6.18 90-day supply list published by the commissioner. The 90-day supply list shall be published  
6.19 by the commissioner on the department's website. The commissioner may add to, delete  
6.20 from, and otherwise modify the 90-day supply list after providing public notice and the  
6.21 opportunity for a 15-day public comment period. The 90-day supply list may include  
6.22 cost-effective generic drugs and shall not include controlled substances.

6.23 (c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical  
6.24 ingredient" is defined as a substance that is represented for use in a drug and when used in  
6.25 the manufacturing, processing, or packaging of a drug becomes an active ingredient of the  
6.26 drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle  
6.27 for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and  
6.28 excipients which are included in the medical assistance formulary. Medical assistance covers  
6.29 selected active pharmaceutical ingredients and excipients used in compounded prescriptions  
6.30 when the compounded combination is specifically approved by the commissioner or when  
6.31 a commercially available product:

6.32 (1) is not a therapeutic option for the patient;

7.1 (2) does not exist in the same combination of active ingredients in the same strengths  
7.2 as the compounded prescription; and

7.3 (3) cannot be used in place of the active pharmaceutical ingredient in the compounded  
7.4 prescription.

7.5 (d) Medical assistance covers the following over-the-counter drugs when prescribed by  
7.6 a licensed practitioner or by a licensed pharmacist who meets standards established by the  
7.7 commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family  
7.8 planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults  
7.9 with documented vitamin deficiencies, vitamins for children under the age of seven and  
7.10 pregnant or nursing women, and any other over-the-counter drug identified by the  
7.11 commissioner, in consultation with the Formulary Committee, as necessary, appropriate,  
7.12 and cost-effective for the treatment of certain specified chronic diseases, conditions, or  
7.13 disorders, and this determination shall not be subject to the requirements of chapter 14. A  
7.14 pharmacist may prescribe over-the-counter medications as provided under this paragraph  
7.15 for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter  
7.16 drugs under this paragraph, licensed pharmacists must consult with the recipient to determine  
7.17 necessity, provide drug counseling, review drug therapy for potential adverse interactions,  
7.18 and make referrals as needed to other health care professionals.

7.19 (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable  
7.20 under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and  
7.21 Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible  
7.22 for drug coverage as defined in the Medicare Prescription Drug, Improvement, and  
7.23 Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these  
7.24 individuals, medical assistance may cover drugs from the drug classes listed in United States  
7.25 Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to  
7.26 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall  
7.27 not be covered.

7.28 (f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing  
7.29 Program and dispensed by 340B covered entities and ambulatory pharmacies under common  
7.30 ownership of the 340B covered entity. Medical assistance does not cover drugs acquired  
7.31 through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

7.32 (g) Notwithstanding paragraph (a), medical assistance covers self-administered hormonal  
7.33 contraceptives prescribed and dispensed by a licensed pharmacist in accordance with section  
7.34 151.37, subdivision 14; nicotine replacement medications prescribed and dispensed by a

8.1 licensed pharmacist in accordance with section 151.37, subdivision 15; and opiate antagonists  
8.2 used for the treatment of an acute opiate overdose prescribed and dispensed by a licensed  
8.3 pharmacist in accordance with section 151.37, subdivision 16.

8.4 (h) Medical assistance coverage for a prescription contraceptive must provide a 12-month  
8.5 supply for any prescription contraceptive if a 12-month supply is prescribed by the  
8.6 prescribing health care provider. The prescribing health care provider must determine the  
8.7 appropriate duration for which to prescribe the prescription contraceptives, up to 12 months.  
8.8 For purposes of this paragraph, "prescription contraceptive" means any drug or device that  
8.9 requires a prescription and is approved by the Food and Drug Administration to prevent  
8.10 pregnancy. Prescription contraceptive does not include an emergency contraceptive drug  
8.11 approved to prevent pregnancy when administered after sexual contact. For purposes of this  
8.12 paragraph, "health plan" has the meaning provided in section 62Q.01, subdivision 3.

8.13 (i) Notwithstanding a removal of a drug from the drug formulary under subdivision 13d,  
8.14 except as provided in paragraphs (j) and (k), medical assistance covers a drug, with respect  
8.15 to an enrollee who was previously prescribed the drug during the calendar year when the  
8.16 drug was on the formulary, at the same level until January 1 of the calendar year following  
8.17 the year in which the commissioner removed the drug from the formulary.

8.18 (j) Paragraph (i) does not apply if the commissioner changes the drug formulary:

8.19 (1) for a drug that has been deemed unsafe by the United States Food and Drug  
8.20 Administration (FDA);

8.21 (2) for a drug that has been withdrawn by the FDA or the drug manufacturer; or

8.22 (3) when an independent source of research, clinical guidelines, or evidence-based  
8.23 standards has issued drug-specific warnings or recommended changes with respect to a  
8.24 drug's use for reasons related to previously unknown and imminent patient harm.

8.25 (k) Paragraph (i) does not apply when the commissioner removes a brand name drug  
8.26 from the formulary if the commissioner adds to the formulary a generic or multisource brand  
8.27 name drug rated as therapeutically equivalent according to the FDA Orange Book, or a  
8.28 biologic drug rated as interchangeable according to the FDA Purple Book, at the same or  
8.29 lower cost to the enrollee.

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

9.1 Sec. 4. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision  
9.2 to read:

9.3 Subd. 77. **Infertility treatment.** (a) Medical assistance covers:

9.4 (1) diagnosis of and treatment for infertility; and

9.5 (2) standard fertility preservation services.

9.6 (b) Medical assistance must meet the same requirements that would otherwise apply to  
9.7 a health plan that provides maternity benefits to Minnesota residents under section 62Q.60,  
9.8 except that medical assistance is not required to comply with any provision of section 62Q.60  
9.9 if compliance with the provision would:

9.10 (1) prevent the state from receiving federal financial participation for the coverage under  
9.11 this subdivision; or

9.12 (2) result in a lower level of coverage or reduced access to coverage for medical assistance  
9.13 enrollees.

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

9.17 Sec. 5. **APPROPRIATIONS; INFERTILITY TREATMENT COVERAGE.**

9.18 Subdivision 1. **Medical assistance.** \$..... in fiscal year 2027 is appropriated from the  
9.19 general fund to the commissioner of human services for medical assistance coverage of  
9.20 infertility treatment and fertility preservation services under Minnesota Statutes, section  
9.21 256B.0625, subdivision 77. The base for this appropriation is \$..... in fiscal year 2028 and  
9.22 \$..... in fiscal year 2029.

9.23 Subd. 2. **MinnesotaCare.** \$..... in fiscal year 2027 is appropriated from the health care  
9.24 access fund to the commissioner of human services for MinnesotaCare coverage of infertility  
9.25 treatment and fertility preservation services under Minnesota Statutes, sections 256L.03,  
9.26 subdivision 1, and 256B.0625, subdivision 77. The base for this appropriation is \$..... in  
9.27 fiscal year 2028 and \$..... in fiscal year 2029.