Bill Summary

H.F. 1257

As amended by H1257DE2

Subject	Drug Benefit Transparency and Prior Authorization
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Overview

This bill requires health plan companies to make formulary and related benefit information available at least 30 days prior to renewal dates, and establishes requirements for health plan company formulary changes. This bill also prohibits certain denials related to lack of prior authorization or second opinion, and requires group purchasers and pharmacy benefit managers to use a real-time prescription benefit tool that meets specified requirements.

Summary

Section	Description
1	**Coverage of service; prior authorization.** Adds § 62A.605. Prohibits a health carrier from denying or limiting coverage of a service an enrollee has already received, solely on the basis of lack of prior authorization or second opinion, if the service would have been covered had prior authorization or second opinion been obtained. States that the section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.
2	**Definitions.** Amends § 62J.497, subd. 1. Defines the following terms: NCPDP Real-Time Prescription Benefit Standard, pharmacy benefit manager, and real-time prescription benefit tool.
3	**Standards for electronic prescribing.** Amends § 62J.497, subd. 3. Requires group purchasers and pharmacy benefit managers (PBMs) to use a real-time prescription benefit tool that complies with the NCPDP Real-Time Prescription Benefit Standard and at a minimum, notifies a prescriber:

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(1) if a drug is covered by the patient's group purchaser or PBM;

(2) if a drug is included on the formulary or preferred drug list of the patient's group purchaser or PBM;

(3) of any patient cost-sharing for the drug;

(4) if prior authorization is required for the drug; and

(5) of alternative drugs in the same class for which prior authorization is not required.

Provides a July 1, 2021, effective date.

4 **Prescription drug benefit transparency and management.**

Adds § 62Q.83.

Subd. 1. Definitions. Defines the following terms: drug, enrollee contract term, formulary, health plan company, and prescription. "Enrollee contract term" is defined as a 12-month term for health plan company products and a calendar quarter for managed care and county-based purchasing plans under MA and MinnesotaCare.

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

(b) Requires formularies to be organized and disclosed consistent with the most recent version of the United States Pharmacopeia's Model Guidelines.

(c) Requires the specific enrollee benefit terms, including cost-sharing and out-of-pocket costs, to be identified for each item or category of items on the formulary.

Subd. 3. Formulary changes. (a) Allows a health plan company, at any time during a contract term, to expand the formulary, reduce copayments or coinsurance, or move a drug to a lower cost benefit category.

(b) Allows a health plan company to remove a brand name drug from the formulary or place the drug in a higher cost benefit category only if a generic or multisource drug rated as therapeutically equivalent, or a biologic drug rated as interchangeable, that is at a lower cost to the enrollee, is added, with at least 60 days' notice.

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(c) Allows a health plan company to change utilization review requirements or move drugs to a higher cost benefit category, that increases enrollee costs during a contract term, only with 60 days' notice, and provides that the changes do not apply to enrollees taking the drugs for the duration of the contract term.

(d) Allows a health plan company to remove drugs from its formulary that have been deemed unsafe by the Food and Drug Administration (FDA), been withdrawn by the FDA or manufacturer, or when an independent source of research, guidelines, or standards has issued drug-specific warnings or recommended changes in drug usage.

5 **Service delivery.**

Amends § 256B.69, subd. 6. Requires managed care and county-based purchasing plans under medical assistance to comply with section 62Q.83.

6 **Repealer.**

Repeals Minnesota Statutes, section 62D.12, subdivision 19, effective January 1, 2021. (This language has been incorporated in section 1 of this bill and expanded to apply to other health carriers.)