State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-THIRD SESSION

H. F. No. 1432

02/08/2023 Authored by Greenman, Liebling, Her, Kozlowski, Wolgamott and others
The bill was read for the first time and referred to the Committee on Commerce Finance and Policy

A bill for an act

relating to health insurance; establishing supply requirements for prescription contraceptives; requiring health plans to cover contraceptive methods, sterilization, and related medical services, patient education, and counseling; establishing accommodations for eligible organizations; amending Minnesota Statutes 2022, section 256B.0625, subdivision 13; proposing coding for new law in Minnesota Statutes, chapter 62Q.

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

Section 1. **[62Q.522] COVERAGE OF CONTRACEPTIVE METHODS AND SERVICES.**

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

(b) "Closely held for-profit entity" means an entity that:

(1) is not a nonprofit entity;

(2) has more than 50 percent of the value of its ownership interest owned directly or indirectly by five or fewer individuals, or has an ownership structure that is substantially similar; and

(3) has no publicly traded ownership interest, having any class of common equity securities required to be registered under United States Code, title 15, section 781.

For purposes of this paragraph:

(i) ownership interests owned by a corporation, partnership, estate, or trust are considered owned proportionately by that entity's shareholders, partners, or beneficiaries;

(ii) ownership interests owned by a nonprofit entity are considered owned by a single owner;

(iii) ownership interests owned by an individual are considered owned, directly or indirectly, by or for the individual's family. For purposes of this item, "family" means brothers and sisters, including half-brothers and half-sisters, a spouse, ancestors, and lineal descendants; and

(iv) if an individual or entity holds an option to purchase an ownership interest, the individual or entity is considered to be the owner of those ownership interests.

(c) "Contraceptive method" means a drug, device, or other product approved by the Food and Drug Administration to prevent unintended pregnancy.

(d) "Contraceptive service" means consultation, examination, procedures, and medical services related to the prevention of unintended pregnancy. This includes but is not limited to voluntary sterilization procedures, patient education, counseling on contraceptives, and follow-up services related to contraceptive methods or services, management of side effects, counseling for continued adherence, and device insertion or removal.

(e) "Eligible organization" means an organization that opposes providing coverage for some or all contraceptive methods or services on account of religious objections and that is:

(1) organized as a nonprofit entity and holds itself as a religious organization; or

(2) organized and operates as a closely held for-profit entity, and the organization's highest governing body has adopted, under the organization's applicable rules of governance and consistent with state law, a resolution or similar action establishing that it objects to covering some or all contraceptive methods or services on account of the owners' sincerely held religious beliefs.

(f) "Medical necessity" includes but is not limited to considerations such as severity of side effects, difference in permanence and reversability of a contraceptive method or service, and ability to adhere to the appropriate use of the contraceptive method or service, as determined by the attending provider.

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

(h) "Therapeutic equivalent version" means a drug, device, or product that can be expected to have the same clinical effect and safety profile when administered to a patient under the conditions specified in the labeling, and that:

(1) is approved as safe and effective;

(2) is a pharmaceutical equivalent, (i) containing identical amounts of the same active drug ingredient in the same dosage form and route of administration, and (ii) meeting compendial or other applicable standards of strength, quality, purity, and identity;

(3) is bioequivalent in that:

(i) the drug, device, or product does not present a known or potential bioequivalence problem and meets an acceptable in vitro standard; or

(ii) if the drug, device, or product does present a known or potential bioequivalence problem, it is shown to meet an appropriate bioequivalence standard;

(4) is adequately labeled; and

(5) is manufactured in compliance with current manufacturing practice regulations.

Subd. 2. **Required coverage; cost sharing prohibited.** (a) A health plan must provide coverage for contraceptive methods and services.

(b) A health plan company must not impose cost-sharing requirements, including co-pays, deductibles, or co-insurance, for contraceptive methods or services.

(c) Notwithstanding paragraph (b), a health plan that is a high-deductible health plan in conjunction with a health savings account must include cost-sharing for contraceptive methods and services at the minimum level necessary to preserve the enrollee's ability to make tax exempt contributions and withdrawals from the health savings account, as provided by section 223 of the Internal Revenue Code of 1986, as amended.

(d) A health plan company must not impose any referral requirements, restrictions, or delays for contraceptive methods or services.

(e) A health plan must include at least one of each type of Food and Drug Administration approved contraceptive method in its formulary. If more than one therapeutic equivalent version of a contraceptive method is approved, a health plan must include at least one therapeutic equivalent version in its formulary, but is not required to include all therapeutic equivalent versions.

(f) For each health plan, a health plan company must list the contraceptive methods and services that are covered without cost-sharing in a manner that is easily accessible to

enrollees, health care providers, and representatives of health care providers. The list for each health plan must be promptly updated to reflect changes to the coverage.

(g) If an enrollee's attending provider recommends a particular contraceptive method or service based on a determination of medical necessity for that enrollee, the health plan must cover that contraceptive method or service without cost-sharing. The health plan company issuing the health plan must defer to the attending provider's determination that the particular contraceptive method or service is medically necessary for the enrollee.

Subd. 3. **Religious employers; exempt** (a) A religious employer is not required to cover contraceptive methods or services if the employer has religious objections to the coverage. A religious employer that chooses to not provide coverage for contraceptive methods and services must notify employees as part of the hiring process and to all employees at least 30 days before:

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

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

(b) If the religious employer provides coverage for some contraceptive methods or services, the notice must provide a list of the contraceptive methods or services the employer refuses to cover.

Subd. 4. **Accommodation for eligible organizations.** (a) A health plan established or maintained by an eligible organization complies with the requirements of subdivision 2 to provide coverage of contraceptive methods and services if the eligible organization provides notice to any health plan company the eligible organization contracts with that it is an eligible organization and that the eligible organization has a religious objection to coverage for all or a subset of contraceptive methods or services.

(b) The notice from an eligible organization to a health plan company under paragraph (a) must include (1) the name of the eligible organization, (2) a statement that it objects to coverage for some or all of contraceptive methods or services, including a list of the contraceptive methods or services the eligible organization objects to, if applicable, and (3) the health plan name. The notice must be executed by a person authorized to provide notice on behalf of the eligible organization.

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

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

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

(d) A health plan company that receives a copy of the notice under paragraph (a) with respect to a health plan established or maintained by an eligible organization must:

(1) expressly exclude coverage for some or all contraceptive methods or services from the health plan; and

(2) provide separate payments for any contraceptive methods or services required to be covered under subdivision 2 for enrollees as long as the enrollee remains enrolled in the health plan.

(e) The health plan company must not impose any cost-sharing requirements, including co-pays, deductibles, or co-insurance, or directly or indirectly impose any premium, fee, or other charge for contraceptive services or methods on the eligible organization, health plan, or enrollee.

(f) On January 1, 2024, and every year thereafter a health plan company must notify the commissioner, in a manner to be determined by the commissioner, regarding the number of eligible organizations granted an accommodation under this subdivision.

EFFECTIVE DATE. This section is effective January 1, 2024, and applies to coverage offered, sold, issued, or renewed on or after that date.

Sec. 2. **[62Q.523] COVERAGE FOR PRESCRIPTION CONTRACEPTIVES; SUPPLY REQUIREMENTS.**

Subdivision 1. **Scope of coverage.** Except as otherwise provided in section 62Q.522, subdivision 3, all health plans that provide prescription coverage must comply with the requirements of this section.

Subd. 2. **Definition.** For purposes of this section, "prescription contraceptive" means any drug or device that requires a prescription and is approved by the Food and Drug Administration to prevent pregnancy. Prescription contraceptive does not include an emergency contraceptive drug that prevents pregnancy when administered after sexual contact.

Subd. 3. **Required coverage.** (a) Health plan coverage for a prescription contraceptive must provide a 12-month supply for any prescription contraceptive, regardless of whether the enrollee was covered by the health plan at the time of the first dispensing.

(b) The prescribing health care provider must determine the appropriate number of months to prescribe the prescription contraceptives for, up to 12 months.

EFFECTIVE DATE. This section is effective January 1, 2024, and applies to coverage offered, sold, issued, or renewed on or after that date.

Sec. 3. Minnesota Statutes 2022, section 256B.0625, subdivision 13, is amended to read:

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

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

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

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

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

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

(d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family

planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the Formulary Committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals.

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

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

(g) Notwithstanding paragraph (a), medical assistance covers self-administered hormonal contraceptives prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 14; nicotine replacement medications prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 15; and opiate antagonists used for the treatment of an acute opiate overdose prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 16.

(h) Medical assistance coverage for a prescription contraceptive must provide a 12-month supply for any prescription contraceptive, regardless of whether the enrollee was covered by medical assistance or the health plan at the time of the first dispensing. The prescribing health care provider must determine the appropriate number of months to prescribe the prescription contraceptives for, up to 12 months.

For purposes of this paragraph, "prescription contraceptive" means any drug or device that requires a prescription and is approved by the Food and Drug Administration to prevent pregnancy. Prescription contraceptive does not include an emergency contraceptive drug approved to prevent pregnancy when administered after sexual contact. For purposes of this paragraph, "health plan" has the meaning provided in section 62Q.01, subdivision 3.

EFFECTIVE DATE. This section applies to medical assistance and MinnesotaCare coverage effective January 1, 2024.