SENATE
STATE OF MINNESOTA
NINETY-FOURTH SESSION

S.F. No. 1876

(SENATE AUTHORS: MANN)

DATE	D-PG	OFFICIAL STATUS
02/27/2025	552	Introduction and first reading
		Referred to Commerce and Consumer Protection
03/13/2025	734a	Comm report: To pass as amended and re-refer to Health and Human Services
03/27/2025		Comm report: To pass as amended and re-refer to Commerce and Consumer Protection

A bill for an act

relating to health; requiring pharmacy benefit managers and health carriers to include lower-cost drugs in their formularies; requiring formulary structure and formulary tiering for each health plan to give preference to the drug with the lowest out-of-pocket cost to the patient; proposing coding for new law in Minnesota Statutes, chapter 62W.

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

Section 1. **[62W.16] INCLUSION OF LOWER-COST DRUGS IN FORMULARY.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Biologic" has the meaning provided in section 62J.86, subdivision 3.

(c) "Biosimilar" has the meaning provided in section 62J.84, subdivision 2, paragraph (b).

(d) "Brand name drug" has the meaning provided in section 62J.84, subdivision 2, paragraph (c).

(e) "Equivalent" means:

(1) with respect to a generic drug, the brand name drug against which the generic drug is evaluated by the United States Food and Drug Administration under United States Code, title 21, section 355(j); and

(2) with respect to a biosimilar, the brand name drug biological product as defined in United States Code, title 42, section 262(i).

(f) "Generic drug" has the meaning provided in section 62J.84, subdivision 2, paragraph (e).

(g) "Health plan" means a policy, contract, certificate, or agreement defined in section 62A.011, subdivision 3.

(h) "Out-of-pocket cost" means any coinsurance, co-payment, or other form of cost-sharing for which a patient is responsible.

(i) "Wholesale acquisition cost" has the meaning provided in section 62J.86, subdivision 11.

Subd. 2. **Brand name, generic, and biosimilar drugs; inclusion of lowest-cost drug in formulary.** (a) If a pharmacy benefit manager or health carrier includes in its formulary a brand name drug, it must also include in its formulary, if applicable, the equivalent generic drug that has a wholesale acquisition cost that is lower than the wholesale acquisition cost of the brand name drug.

(b) If a pharmacy benefit manager or health carrier includes in its formulary a generic drug, it must also include in its formulary, if applicable, the brand name drug to which the generic drug is equivalent, if the brand name drug has a wholesale acquisition cost that is lower than the wholesale acquisition cost of the generic drug included in the formulary.

(c) If a pharmacy benefit manager or health carrier includes in its formulary a brand name biologic, it must also include in its formulary, if applicable, the equivalent biosimilar that has a wholesale acquisition cost that is lower than:

(1) the wholesale acquisition cost of the brand name biologic; and

(2) the wholesale acquisition cost of any other equivalent biosimilar.

(d) If a pharmacy benefit manager or health carrier includes in its formulary a biosimilar, it must also include in its formulary, if applicable, the brand name biologic to which the biosimilar is equivalent, if the brand name biologic has a wholesale acquisition cost that is lower than:

(1) the wholesale acquisition cost of the biosimilar included in the formulary; and

(2) the wholesale acquisition cost of any other equivalent biosimilar.

Subd. 3. **New generic and biosimilar drugs; inclusion of lowest-cost drug in formulary.** (a) If a generic drug is approved by the United States Food and Drug Administration, is marketed pursuant to that approval, and has a wholesale acquisition cost that is less than the brand name drug already included in the formulary of a pharmacy benefit

manager or health carrier, the pharmacy benefit manager or health carrier must immediately make the newly approved generic drug available on its formulary.

(b) If a biosimilar is approved by the United States Food and Drug Administration, is marketed pursuant to that approval, and has a wholesale acquisition cost that is less than the brand name biologic or biosimilar with the lowest wholesale acquisition cost already included in the formulary of a pharmacy benefit manager or health carrier, the pharmacy benefit manager or health carrier must immediately make the newly approved biosimilar available on its formulary.

Subd. 4. **Formulary structure and tiering.** (a) A pharmacy benefit manager or health carrier must structure its formulary and any formulary tiers for each health plan in a manner that gives preference to the brand name drug or the equivalent generic drug that has the lowest out-of-pocket cost to the patient purchasing the drug product. The pharmacy benefit manager or health carrier must not impose any prior authorization or step therapy requirement or other limitation on coverage of the drug product with the lowest out-of-pocket cost to the patient under the patient's health plan, or impose a restriction on a pharmacy that makes it more difficult for the patient under the patient's health plan to obtain coverage of or access to the drug product with the lowest out-of-pocket cost to the patient.

(b) A pharmacy benefit manager or health carrier must structure its formulary and any formulary tiers for each health plan in a manner that gives preference to the brand name biologic or the equivalent biosimilar that has the lowest out-of-pocket cost to the patient purchasing the drug product. The pharmacy benefit manager or health carrier must not impose any prior authorization or step therapy requirement or other limitation on coverage of the drug product with the lowest out-of-pocket cost to the patient under the patient's health plan, or impose a restriction on a pharmacy that makes it more difficult for the patient under the patient's health plan to obtain coverage of or access to the drug product with the lowest out-of-pocket cost to the patient.

EFFECTIVE DATE. This section is effective January 1, 2026.