State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FIRST SESSION

H. F. No. 3031

02/11/2020 Authored by Cantrell
The bill was read for the first time and referred to the Committee on Commerce

A bill for an act

relating to health care coverage; prohibiting health carriers from limiting or denying coverage due to a lack of prior authorization; requiring use of a real-time prescription benefit tool; requiring prescription drug benefit transparency and disclosure; amending Minnesota Statutes 2018, section 62J.497, subdivisions 1, 3; proposing coding for new law in Minnesota Statutes, chapters 62A; 62Q; repealing Minnesota Statutes 2018, section 62D.12, subdivision 19.

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

Section 1. **[62A.605] COVERAGE OF SERVICE; PRIOR AUTHORIZATION.**

A health carrier may not deny or limit coverage of a service that an enrollee has already received solely on the basis of lack of prior authorization or second opinion, to the extent that the service would otherwise have been covered by the health carrier under the enrollee's health plan had prior authorization or second opinion been obtained.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 2. Minnesota Statutes 2018, section 62J.497, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given.

(b) "Backward compatible" means that the newer version of a data transmission standard would retain, at a minimum, the full functionality of the versions previously adopted, and would permit the successful completion of the applicable transactions with entities that continue to use the older versions.

(c) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30. Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.

(d) "Dispenser" means a person authorized by law to dispense a controlled substance, pursuant to a valid prescription.

(e) "Electronic media" has the meaning given under Code of Federal Regulations, title 45, part 160.103.

(f) "E-prescribing" means the transmission using electronic media of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or group purchaser, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser and two-way transmissions related to eligibility, formulary, and medication history information.

(g) "Electronic prescription drug program" means a program that provides for e-prescribing.

(h) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

(i) "HL7 messages" means a standard approved by the standards development organization known as Health Level Seven.

(j) "National Provider Identifier" or "NPI" means the identifier described under Code of Federal Regulations, title 45, part 162.406.

(k) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

(l) "NCPDP Formulary and Benefits Standard" means the National Council for Prescription Drug Programs Formulary and Benefits Standard, Implementation Guide, Version 1, Release 0, October 2005.

(m) "NCPDP Real-Time Prescription Benefit Standard" means the most recent National Council for Prescription Drug Programs Real-Time Prescription Benefit Standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(2) of the Social Security Act, and regulations adopted under it.

~~(m)~~ (n) "NCPDP SCRIPT Standard" means the National Council for Prescription Drug Programs Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide Version 8, Release 1 (Version 8.1), October 2005, or the most recent standard adopted by the Centers

for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act, and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance. Subsequently released versions of the NCPDP SCRIPT Standard may be used, provided that the new version of the standard is backward compatible to the current version adopted by the Centers for Medicare and Medicaid Services.

~~(n)~~ (o) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

(p) "Pharmacy benefit manager" has the meaning given in section 62W.02, subdivision 15.

~~(o)~~ (q) "Prescriber" means a licensed health care practitioner, other than a veterinarian, as defined in section 151.01, subdivision 23.

~~(p)~~ (r) "Prescription-related information" means information regarding eligibility for drug benefits, medication history, or related health or drug information.

~~(q)~~ (s) "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

(t) "Real-time prescription benefit tool" means a tool that is capable of being integrated into a prescriber's e-prescribing system and that provides a prescriber with up-to-date and patient-specific formulary and benefit information at the time the prescriber submits a prescription.

Sec. 3. Minnesota Statutes 2018, section 62J.497, subdivision 3, is amended to read:

Subd. 3. **Standards for electronic prescribing.** (a) Prescribers and dispensers must use the NCPDP SCRIPT Standard for the communication of a prescription or prescription-related information. The NCPDP SCRIPT Standard shall be used to conduct the following transactions:

(1) get message transaction;

(2) status response transaction;

(3) error response transaction;

(4) new prescription transaction;

(5) prescription change request transaction;

(6) prescription change response transaction;

(7) refill prescription request transaction;

(8) refill prescription response transaction;

(9) verification transaction;

(10) password change transaction;

(11) cancel prescription request transaction; and

(12) cancel prescription response transaction.

(b) Providers, group purchasers, prescribers, and dispensers must use the NCPDP SCRIPT Standard for communicating and transmitting medication history information.

(c) Providers, group purchasers, prescribers, and dispensers must use the NCPDP Formulary and Benefits Standard for communicating and transmitting formulary and benefit information.

(d) Providers, group purchasers, prescribers, and dispensers must use the national provider identifier to identify a health care provider in e-prescribing or prescription-related transactions when a health care provider's identifier is required.

(e) Providers, group purchasers, prescribers, and dispensers must communicate eligibility information and conduct health care eligibility benefit inquiry and response transactions according to the requirements of section 62J.536.

(f) Group purchasers and pharmacy benefit managers must use a real-time prescription benefit tool that complies with the NCPDP Real-Time Prescription Benefit Standard and that, at a minimum, notifies a prescriber:

(1) if a prescribed drug is covered by the patient's group purchaser or pharmacy benefit manager;

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

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

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

(5) a list of any available alternative drugs that are in the same class as the drug originally prescribed and for which prior authorization is not required.

EFFECTIVE DATE. This section is effective January 1, 2021.

Sec. 4. **[62Q.83] PRESCRIPTION DRUG BENEFIT TRANSPARENCY AND MANAGEMENT.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them.

(b) "Drug" has the meaning given in section 151.01, subdivision 5.

(c) "Enrollee contract term" means the 12-month term during which benefits associated with health plan company products are in effect. For managed care plans and county-based purchasing plans under section 256B.69 and chapter 256L, it means a single calendar quarter.

(d) "Formulary" means a list of prescription drugs that have been developed by clinical and pharmacy experts and represents the health plan company's medically appropriate and cost-effective prescription drugs approved for use.

(e) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, and includes an entity that performs pharmacy benefits management for the health plan company. For purposes of this definition, "pharmacy benefits management" means the administration or management of prescription drug benefits provided by the health plan company for the benefit of its enrollees and may include but is not limited to procurement of prescription drugs, clinical formulary development and management services, claims processing, and rebate contracting and administration.

(f) "Prescription" has the meaning given in section 151.01, subdivision 16a.

Subd. 2. **Prescription drug benefit disclosure.** (a) A health plan company that provides prescription drug benefit coverage and uses a formulary must 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) Formularies must be organized and disclosed consistent with the most recent version of the United States Pharmacopeia's (USP) Model Guidelines.

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

Subd. 3. **Formulary changes.** (a) Once a formulary has been established, a health plan company may, at any time during the enrollee's contract term:

(1) expand its formulary by adding drugs to the formulary;

(2) reduce co-payments or coinsurance; or

(3) move a drug to a benefit category that reduces an enrollee's cost.

(b) A health plan company may remove a brand name drug from its formulary or place a brand name drug in a benefit category that increases an enrollee's cost only upon the addition to the formulary of a generic or multisource brand name drug rated as therapeutically equivalent according to the FDA Orange Book or a biologic drug rated as interchangeable according to the FDA Purple Book at a lower cost to the enrollee, and upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees.

(c) A health plan company may change utilization review requirements or move drugs to a benefit category that increases an enrollee's cost during the enrollee's contract term upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees, provided that these changes do not apply to enrollees who are currently taking the drugs affected by these changes for the duration of the enrollee's contract term.

(d) A health plan company may remove any drugs from its formulary that have been deemed unsafe by the Food and Drug Administration, that have been withdrawn by either the Food and Drug Administration or the product manufacturer, or when an independent source of research, clinical guidelines, or evidence-based standards have issued drug-specific warnings or recommended changes in drug usage.

Sec. 5. **REPEALER.**

Minnesota Statutes 2018, section 62D.12, subdivision 19, is repealed.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

62D.12 PROHIBITED PRACTICES.

Subd. 19. **Coverage of service.** A health maintenance organization may not deny or limit coverage of a service which the enrollee has already received solely on the basis of lack of prior authorization or second opinion, to the extent that the service would otherwise have been covered under the member's contract by the health maintenance organization had prior authorization or second opinion been obtained.