256B.696 PRESCRIPTION DRUGS; STATE PHARMACY BENEFIT MANAGER.

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

(b) "Managed care enrollees" means medical assistance and MinnesotaCare enrollees receiving coverage from managed care plans.

(c) "Managed care organizations" means health plan companies and county-based purchasing organizations providing coverage to medical assistance and MinnesotaCare enrollees under the managed care delivery system.

(d) "State pharmacy benefit manager" means the pharmacy benefit manager selected pursuant to the procurement process in subdivision 2.

[See Note.]

Subd. 2. **Procurement process.** (a) The commissioner must, through a competitive procurement process in compliance with paragraph (b), select a state pharmacy benefit manager to comply with the requirements set forth in subdivision 3. The state pharmacy benefit manager selected under this subdivision must be a prepaid ambulatory health plan, as defined in Code of Federal Regulations, title 42, section 438.2.

(b) When selecting the state pharmacy benefit manager, the commissioner must:

(1) accept applications for entities seeking to become the state pharmacy benefit manager;

(2) establish eligibility criteria an entity must meet in order to become the state pharmacy benefit manager; and

(3) enter into a master contract with a single pharmacy benefit manager.

(c) Applicants for the state pharmacy benefit manager must disclose to the commissioner the following during the procurement process:

(1) any activity, policy, practice, contract, or arrangement of the pharmacy benefit manager that may directly or indirectly present any conflict of interest with the pharmacy benefit manager's relationship with or obligation to the Department of Human Services or a managed care organization;

(2) all common ownership, members of a board of directors, managers, or other control of the pharmacy benefit manager or any of the pharmacy benefit manager's affiliated companies with:

(i) a managed care organization administering medical assistance or MinnesotaCare benefits in Minnesota or an affiliate of the managed care organization;

(ii) an entity that contracts on behalf of a pharmacy or any pharmacy services administration organization and its affiliates;

(iii) a drug wholesaler or distributor and its affiliates;

(iv) a third-party payer and its affiliates; or

(v) a pharmacy and its affiliates;

(3) any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in the state with which the pharmacy benefit manager shares common

ownership, management, or control, or that are owned, managed, or controlled by any of the pharmacy benefit manager's affiliated companies;

(4) any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in the state; and

(5) any financial terms and arrangements between the pharmacy benefit manager and a prescription drug manufacturer or labeler, including formulary management, drug substitution programs, educational support claims processing, or data sales fees.

[See Note.]

Subd. 3. **Contract requirements.** The master contract required under subdivision 2, paragraph (b), clause (3), must include provisions that prohibit the state pharmacy benefit manager from:

(1) requiring, enticing, or coercing an enrollee to obtain pharmacy services, including a prescription drug, from a pharmacy owned or otherwise affiliated with the state pharmacy benefit manager;

(2) communicating to an enrollee, in any manner, that the enrollee is required to obtain pharmacy services or have a prescription dispensed at, or pharmacy services provided by, a particular pharmacy owned or affiliated with the state pharmacy benefit manager if there are other nonaffiliated pharmacies that have the ability to dispense the medication or provide the services and are also in network;

(3) requiring an enrollee to obtain pharmacy services, including a prescription drug, exclusively through a mail order pharmacy;

(4) directly or indirectly retroactively denying or reducing a claim or aggregate of claims for pharmacy services, including prescription drugs, after adjudication of the claim or aggregation of claims; and

(5) paying a rate for pharmacy services, including the prescription drug, that is less than the sum of the following:

(i) the amount of the professional dispensing fee if it were determined pursuant to section 256B.0625, subdivision 13e; and

(ii) either:

(A) the lower of the national average drug acquisition cost or the Minnesota actual acquisition cost under section 256B.0625, subdivision 13e, paragraph (i);

(B) the maximum allowable cost, as described in section 62W.08, if the national average drug acquisition cost and the Minnesota actual acquisition cost are unreported; or

(C) the wholesale acquisition cost minus two percent at the time the drug is administered or dispensed if the costs of subitems (A) and (B) are unreported or unavailable.

[See Note.]

Subd. 4. **Prescription drug coverage requirements.** (a) The state pharmacy benefit manager is responsible for processing all point of sale outpatient pharmacy claims under the managed care delivery system. Managed care and county-based purchasing plans must use the state pharmacy benefit manager pursuant to the terms of the master contract required under subdivision 2, paragraph (b), clause (3). The state pharmacy benefit manager selected is the exclusive pharmacy benefit manager used by managed care and county-based purchasing plans when providing coverage to enrollees. The commissioner may require

the managed care and county-based purchasing plans and state pharmacy benefit manager to directly exchange data and files for members enrolled with the plans.

(b) The commissioner may require the state pharmacy benefit manager to modify utilization review limitations, requirements, and strategies imposed on prescription drug coverage.

(c) All payment arrangements between the Department of Human Services, managed care plans, county-based purchasing plans, and the state pharmacy benefit manager must comply with state and federal statutes, regulations adopted by the Centers for Medicare and Medicaid Services, and any other agreement between the department and the Centers for Medicare and Medicaid Services. The commissioner may change a payment arrangement to comply with this paragraph.

(d) The commissioner must administer and oversee this section to:

(1) ensure proper administration of prescription drug benefits for managed care enrollees; and

(2) increase the transparency of prescription drug prices and other information for the benefit of pharmacies.

[See Note.]

Subd. 5. **Reporting requirements.** (a) The state pharmacy benefit manager must, on request from the commissioner, disclose to the commissioner all sources of payment the state pharmacy benefit manager receives for prescribed drugs, including drug rebates, discounts, credits, clawbacks, fees, grants, chargebacks, reimbursements, or other financial benefits or payments related to services provided for a managed care or county-based purchasing plan.

(b) Each managed care and county-based purchasing plan must disclose to the commissioner, in the format specified by the commissioner, the entity's administrative costs associated with providing pharmacy services under the managed care delivery system.

(c) The state pharmacy benefit manager must provide a written quarterly report to the commissioner containing the following information from the immediately preceding quarter:

(1) the prices the state pharmacy benefit manager negotiated for prescribed drugs under the managed care delivery system. The prices must include any rebates the state pharmacy benefit manager received from drug manufacturers;

(2) unredacted copies of contracts between the state pharmacy benefit manager and enrolled pharmacies;

(3) any rebate amounts the state pharmacy benefit manager passed on to individual pharmacies;

(4) any changes to the information previously disclosed in accordance with subdivision 2, paragraph (c); and

(5) any other information required by the commissioner.

(d) Data submitted pursuant to paragraph (c), clause (3), are nonpublic data, as defined in section 13.02, subdivision 9.

(e) The commissioner may request and collect additional information and clinical data from the state pharmacy benefit manager.

(f) At the time of contract execution, renewal, or modification, the commissioner must modify the reporting requirements under its managed care contracts as necessary to meet the requirements of this subdivision.

[See Note.]

Subd. 6. **Commissioner's program authority.** (a) To accomplish the requirements of subdivision 4, paragraph (d), the commissioner, in consultation with the Formulary Committee established under section 256B.0625, subdivision 13c, has the authority to:

(1) adopt or develop a preferred drug list for managed care plans;

(2) at the commissioner's discretion, engage in price negotiations with prescription drug manufacturers, wholesalers, or group purchasing organizations in place of the state pharmacy benefit manager to obtain price discounts and rebates for prescription drugs for managed care enrollees; and

(3) develop and manage a drug formulary for managed care and county-based purchasing plans.

(b) The commissioner may contract with one or more entities to perform any of the functions described in paragraph (a).

[See Note.]

Subd. 7. **Contracts with pharmacies.** (a) The commissioner may review contracts between the state pharmacy benefit manager and pharmacies for compliance with this section and the master contract required under subdivision 2, paragraph (b), clause (3). The commissioner may amend any term or condition of a contract that does not comply with this section or the master contract.

(b) A master contract and a contract between a state pharmacy benefit manager and a pharmacy are nonpublic data, as defined in section 13.02, subdivision 9.

[See Note.]

Subd. 8. **Federal approval.** (a) The commissioner must seek any necessary federal approval to implement this section.

(b) The commissioner shall monitor the effect of state directed payments under this section on access to pharmaceutical services in rural and underserved areas of Minnesota. If, for any contract year, federal approval is not received for a state directed payment under this section, the commissioner must adjust payments made to the managed care entity for that contract year to reflect removal of the payment. Contracts between the state pharmacy benefit manager and providers to whom this section applies must allow recovery of payments from those providers if rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from state directed payments under this section. This paragraph expires if federal approval is not received for state directed payments under this section at any time.

History: *1Sp2025 c 3 art 4 s 9*

NOTE: Subdivisions 1 to 7, as added by Laws 2025, First Special Session chapter 3, article 4, section 9, are effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 3, article 4, section 9, the effective date.