State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FOURTH SESSION

H. F. No. 1485

A bill for an act

relating to health insurance; requiring coverage of over-the-counter contraceptive drugs, devices, and products by insurers and medical assistance; requiring reports; amending Minnesota Statutes 2024, sections 62Q.522, subdivisions 1, 2; 256B.0625, subdivision 13.

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

Section 1. Minnesota Statutes 2024, section 62Q.522, subdivision 1, is amended to read:

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

(b) "Contraceptive method" means a ~~drug, device, or other product approved by the Food and Drug Administration to prevent unintended pregnancy~~ prescription contraceptive or over-the-counter contraceptive.

(c) "Contraceptive service" or "service" means consultation, examination, procedures, and medical services related to the prevention of unintended pregnancy, excluding vasectomies. 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.

(d) "Medical necessity" includes but is not limited to considerations such as severity of side effects, difference in permanence and reversibility 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.

(e) "Over-the-counter contraceptive" or "OTC contraceptive" means a drug, device, or other product that:

(1) is approved by the Food and Drug Administration to prevent unintended pregnancy; and

(2) does not require a prescription.

(f) "Pharmacy" has the meaning given in section 151.01.

(g) "Prescription contraceptive" means a drug, device, or other product that:

(1) is approved by the Food and Drug Administration to prevent unintended pregnancy; and

(2) requires a prescription.

~~(e)~~ (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.

EFFECTIVE DATE. This section is effective January 1, 2026, and applies to health plans offered, issued, or renewed on or after that date.

Sec. 2. Minnesota Statutes 2024, section 62Q.522, subdivision 2, is amended to read:

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 coinsurance, for contraceptive methods or services.

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

(d) A health plan must include at least one of each type of Food and Drug Administration approved contraceptive method in its formulary. Subject to paragraph (g), 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.

(e) 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.

(f) 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.

(g) Notwithstanding paragraph (d), a health plan must cover all types and brands of OTC contraceptives purchased at a pharmacy without requiring a prescription.

(h) A health plan must cover all OTC contraceptives purchased at a pharmacy at the point-of-sale without requiring a prescription.

(i) A health plan must not limit the type, quantity, or purchase frequency, and must not impose any restriction or requirement, based on prescription status of OTC contraceptives purchased at a pharmacy.

(j) If the application of this subdivision before an enrollee has met the enrollee's health plan's deductible results in: (1) health savings account ineligibility under United States Code, title 26, section 223; or (2) catastrophic health plan ineligibility under United States Code, title 42, section 18022(e), then this subdivision applies to contraceptive methods and services only after the enrollee has met the enrollee's health plan's deductible.

EFFECTIVE DATE. This section is effective January 1, 2026, and applies to health plans offered, issued, or renewed on or after that date.

Sec. 3. Minnesota Statutes 2024, 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:

(1) 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:

(i) antacids~~,~~;

(ii) acetaminophen~~,~~;

(iii) family planning products~~,~~;

(iv) aspirin~~,~~;

(v) insulin~~,~~;

(vi) products for the treatment of lice~~,~~;

(vii) vitamins for adults with documented vitamin deficiencies~~,~~;

(viii) vitamins for children under the age of seven and pregnant or nursing women~~,~~; and

(ix) 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~~

(2) all over-the-counter contraceptives, as defined in section 62Q.522, regardless of whether the drug has been prescribed.

A determination ~~shall~~ by the commissioner under clause (1), item (ix), is 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 if a 12-month supply is prescribed by the prescribing health care provider. The prescribing health care provider must determine the appropriate duration for which to prescribe the prescription contraceptives, 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 is effective January 1, 2026.

Sec. 4. **OUTREACH AND REPORTS.**

(a) The Department of Commerce must work with the Departments of Health and Human Services to provide public information about over-the-counter contraception coverage.

(b) The Department of Commerce must work with the Departments of Health and Human Services and provide a report by March 31, 2027, and annually thereafter, to the standing committees of the legislature with oversight of issues relating to commerce, health, and human services. The report must include information and data regarding the use of coverage and related costs to health plans and the state to provide over-the-counter contraceptives.