State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FOURTH SESSION

H. F. No. 1758

03/03/2025 Authored by Kotyza-Witthuhn, Engen and Long
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 insurance; requiring health plans to cover infertility treatment and standard fertility preservation services; requiring medical assistance and MinnesotaCare to cover infertility treatment and standard fertility preservation services; appropriating money; amending Minnesota Statutes 2024, section 256B.0625, subdivision 13, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 62Q.

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

Section 1. **[62Q.60] COVERAGE OF INFERTILITY TREATMENT.**

Subdivision 1. **Scope.** This section applies to all health plans that provide maternity benefits to Minnesota residents.

Subd. 2. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given.

(b) "Diagnosis of and treatment for infertility" means procedures and medications:

(1) to diagnose or treat infertility; and

(2) consistent with established, published, or approved medical practices or professional guidelines from the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine.

(c) "Infertility" means a disease, condition, or status characterized by:

(1) the failure of a person with a uterus to establish a pregnancy or to carry a pregnancy to live birth after the following duration of unprotected sexual intercourse, regardless of whether a pregnancy resulted in miscarriage during such time:

(i) for a person under the age of 35, 12 months duration; or

(ii) for a person 35 years of age or older, six months duration;

(2) a person's inability to reproduce without medical intervention either as a single individual or with the person's partner; or

(3) a licensed health care provider's determination that a patient is infertile based on the patient's medical, sexual, and reproductive history; age; physical findings; or diagnostic testing.

(d) "Standard fertility preservation services" means procedures that are consistent with the established medical practices or professional guidelines published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology for a person who has a medical condition or is expected to undergo medication therapy, surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment to fertility.

Subd. 3. **Required coverage.** (a) Health plans must provide comprehensive coverage for:

(1) diagnosis of and treatment for infertility; and

(2) standard fertility preservation services.

(b) Coverage under this section must include unlimited embryo transfers, but may impose a limit of four completed oocyte retrievals. Single embryo transfer must be used when medically appropriate and recommended by the treating health care provider.

(c) Coverage for surgical reversal of elective sterilization is not required under this section.

Subd. 4. **Cost-sharing requirements.** A health plan must not impose on the coverage under this section any cost-sharing requirement that is greater than the cost-sharing requirement imposed on maternity coverage under the plan, including but not limited to the following requirements:

(1) co-payment;

(2) deductible; or

(3) coinsurance.

Subd. 5. **Exclusions and limitations.** (a) A health plan must not impose any benefit maximum, waiting period, utilization review, referral requirement, or any other limitation

on the coverage under this section, except as provided in subdivision 3, paragraphs (b) and (c), that is not generally applicable to maternity coverage under the health plan.

(b) The prohibition under this subdivision includes but is not limited to any exclusion, limitation, or other restriction on:

(1) fertility medications that are different from those imposed on other prescription medications; and

(2) any fertility services based on an enrollee's participation in fertility services provided by or to a third party.

Subd. 6. **Reimbursement.** (a) The commissioner of commerce must reimburse health plan companies for coverage under this section. Reimbursement is available only for coverage that would not have been provided by the health plan without the requirements of this section. Treatments and services covered by the health plan as of January 1, 2025, are ineligible for payment under this subdivision by the commissioner of commerce.

(b) Health plan companies must report to the commissioner of commerce quantified costs attributable to the additional benefit under this section in a format developed by the commissioner. A health plan's coverage as of January 1, 2025, must be used by the health plan company as the basis for determining whether coverage would not have been provided by the health plan for purposes of this subdivision.

(c) The commissioner of commerce must evaluate submissions and make payments to health plan companies as provided in Code of Federal Regulations, title 45, section 155.170.

Subd. 7. **Appropriation.** Each fiscal year, an amount necessary to make payments to health plan companies to defray the cost of providing coverage under this section is appropriated to the commissioner of commerce.

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

Sec. 2. 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 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 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, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 3. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision to read:

Subd. 77. **Infertility treatment.** (a) Medical assistance covers:

(1) diagnosis of and treatment for infertility; and

(2) standard fertility preservation services.

(b) Medical assistance must meet the same requirements that would otherwise apply to a health plan that provides maternity benefits to Minnesota residents under section 62Q.60, except that medical assistance is not required to comply with any provision of section 62Q.60 if compliance with the provision would:

(1) prevent the state from receiving federal financial participation for the coverage under this subdivision; or

(2) result in a lower level of coverage or reduced access to coverage for medical assistance enrollees.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 4. **APPROPRIATIONS; INFERTILITY TREATMENT COVERAGE.**

Subdivision 1. **Medical assistance.** $..... in fiscal year 2026 and $..... in fiscal year 2027 are appropriated from the general fund to the commissioner of human services for medical assistance coverage of infertility treatment and fertility preservation services under Minnesota Statutes, section 256B.0625, subdivision 77. The base for this appropriation is $..... in fiscal year 2028.

Subd. 2. **MinnesotaCare.** $..... in fiscal year 2026 and $..... in fiscal year 2027 are appropriated from the health care access fund to the commissioner of human services for MinnesotaCare coverage of infertility treatment and fertility preservation services under Minnesota Statutes, section 256L.03, subdivision 1. The base for this appropriation is $..... in fiscal year 2028.

Subd. 3. **Defrayal of costs.** $..... in fiscal year 2027 is appropriated from the general fund to the commissioner of commerce for the estimated amount of defrayal costs for mandated coverage of infertility treatment and fertility preservation services. The base for this appropriation is $..... in fiscal year 2028.

Subd. 4. **Administrative costs.** $..... in fiscal year 2027 is appropriated from the general fund to the commissioner of commerce for administrative costs to implement mandated coverage of infertility treatment and fertility preservation services. The base for this appropriation is $..... in fiscal year 2028.