State PBM Reform Inventory

Updated October 2026

Minnesota

Issue	Summary	Citation
Licensing/Registration	No person shall perform, act, or do business in this state as a PBM unless the person has a valid license issued under this chapter by the Commissioner of Commerce. A PBM seeking a license shall apply using a form prescribed by the commissioner and pay a nonrefundable fee of $8,500. A license issued under this chapter is valid for one year. To renew a license, an applicant must submit a completed renewal application on a form prescribed by the commissioner, the network adequacy report required under section 62W.05, and a renewal fee of $8,500.	MRS § 62W.03
Reporting Requirements	Beginning in the second quarter after the effective date of a contract between a PBM and a plan sponsor, the PBM must disclose, upon the request of the plan sponsor, the following information: • The aggregate WACs from a drug manufacturer or wholesale drug distributor for each therapeutic category of prescription drugs; • The aggregate WACs from a drug manufacturer or wholesale drug distributor for each therapeutic category of prescription drugs available to the plan sponsor's enrollees; • The aggregate amount of rebates received by the PBM by therapeutic category of prescription drugs. The aggregate amount of rebates must include any utilization discounts the PBM receives from a drug manufacturer or wholesale drug distributor; • Any other fees received from a drug manufacturer or wholesale drug distributor; • Whether the PBM has a contract, agreement, or other arrangement with a drug manufacturer to exclusively dispense or provide a drug to a plan sponsor's enrollees, and the application of all consideration or economic benefits collected or received pursuant to the arrangement;	MRS § 62W.06; MRS § 62W.07

	• Prescription drug utilization information for the plan sponsor's enrollees;
	• De-identified claims level information in electronic format that allows the plan sponsor to sort and analyze the following information for each claim:
	  ○ Whether the claim required prior authorization;
	  ○ The amount paid to the pharmacy for each prescription, net of the aggregate amount of fees or other assessments imposed on the pharmacy, including point-of-sale and retroactive charges;
	  ○ Any spread between the net amount paid to the pharmacy and the amount charged to the plan sponsor;
	  ○ Whether the pharmacy is, or is not, under common control or ownership with the PBM;
	  ○ Whether the pharmacy is, or is not, a preferred pharmacy under the plan;
	  ○ Whether the pharmacy is, or is not, a mail order pharmacy; and
	  ○ Whether enrollees are required by the plan to use the pharmacy;
	• The aggregate amount of payments made by the PBM to pharmacies owned or controlled by the PBM on behalf of the sponsor's plan;
	• The aggregate amount of payments made by the PBM to pharmacies not owned or controlled by the PBM on behalf of the sponsor's plan; and
	• The aggregate amount of the fees imposed on, or collected from, network pharmacies or other assessments against network pharmacies, including point-of-sale fees and retroactive charges, and the application of those amounts collected pursuant to the contract with the plan sponsor.
	
	Each year, the PBM must submit to the commissioner a transparency report containing data from the prior calendar year as it pertains to plan sponsors doing business in Minnesota. The report must contain the following information:
	• The aggregate WACs from a drug manufacturer or wholesale drug distributor for each therapeutic category of prescription drugs for all of the PBM's plan sponsor clients, and these costs net of all rebates and other fees and payments, direct or indirect, from all sources;	

	• The aggregate amount of all rebates that the PBM received from all drug manufacturers for all the PBM's plan sponsor clients. The aggregate amount of rebates must include any utilization discounts the PBM receives from a drug manufacturer or wholesale drug distributor;
	• The aggregate of all fees from all sources, direct or indirect, that the PBM received for all PBM's plan sponsor clients;
	• The aggregate retained rebates and other fees that the PBM received from all sources, direct or indirect, that were not passed through to plan sponsors;
	• The aggregate retained rebate and fees percentage;
	• The highest, lowest, and mean aggregate retained rebate and fees percentage for all the PBM's plan sponsor clients; and
	• De-identified claims-level information in electronic format that allows the commissioner to sort and analyze the following information for each claim:
	  ○ The drug and quantity for each prescription;
	  ○ Whether the claim required prior authorization;
	  ○ Patient cost-sharing paid on each prescription;
	  ○ The amount paid to the pharmacy for each prescription, net of the aggregate amount of fees or other assessments imposed on the pharmacy, including point-of-sale and retroactive charges;
	  ○ Any spread between the net amount paid to the pharmacy and the amount charged to the plan sponsor;
	  ○ Identity of the pharmacy for each prescription;
	  ○ Whether the pharmacy is, or is not, under common control or ownership with the PBM;
	  ○ Whether the pharmacy is, or is not, a preferred pharmacy under the plan;
	  ○ Whether the pharmacy is, or is not, a mail order pharmacy; and
	  ○ Whether enrollees are required by the plan to use the pharmacy.
	
	A PBM that has an ownership interest either directly or indirectly, or through an affiliate or subsidiary, in a pharmacy must disclose to a plan sponsor that contracts with the PBM any difference between the amount paid to that pharmacy and the amount charged to the plan sponsor.	

PBM Income	N/A	
Pharmacy Contracting	**Patient Steering:** A PBM or health carrier is prohibited from penalizing, requiring, or providing financial incentives, including variations in premiums, deductibles, co-payments, or coinsurance, to an enrollee as an incentive to use a retail pharmacy, mail order pharmacy, specialty pharmacy, or other network pharmacy provider in which a PBM has an ownership interest or in which the pharmacy provider has an ownership interest in the PBM. This requirement does not apply if the PBM or health carrier offers an enrollee the same financial incentives for using a network retail pharmacy, mail order pharmacy, specialty pharmacy, or other network pharmacy in which the PBM has no ownership interest and the network pharmacy has agreed to accept the same pricing terms, conditions, and requirements related to the cost of the prescription drug and the cost of dispensing the prescription drug that are in the agreement with a network pharmacy in which the PBM has an ownership interest. In addition, a PBM or health carrier is prohibited from imposing limits, including quantity limits or refill frequency limits, on an enrollee's access to medication that differ based solely on whether the health carrier or PBM has an ownership interest in a pharmacy or the pharmacy has an ownership interest in the PBM. **MAC Pricing:** With respect to each contract and contract renewal between a PBM and a pharmacy, the PBM must: • Provide to the pharmacy, at the beginning of each contract and contract renewal, the sources utilized to determine the MAC pricing of the PBM; • Update any MAC price list at least every 7 business days, noting any price changes from the previous list, and provide a means by which network pharmacies may promptly review current prices in an electronic, print, or telephonic format within 1 business day at no cost to the pharmacy; • Maintain a procedure to eliminate products from the list of drugs subject to MAC pricing in a timely manner in order to remain consistent with changes in the marketplace;	MRS § 62W.07; MRS § 62W.08

	• Ensure that the MAC prices are not set below sources utilized by the PBM; and • Upon request of a network pharmacy, disclose the sources utilized for setting MAC price rates on each MAC price list included under the contract and identify each MAC price list that applies to the network pharmacy. A PBM must make the list of the MACs available to a contracted pharmacy in a format that is readily accessible and usable to the network pharmacy. A PBM must not place a prescription drug on a MAC list unless the drug is available for purchase by pharmacies in this state from a national or regional drug wholesaler and is not obsolete. Each contract between a PBM and a pharmacy must include a process to appeal, investigate, and resolve disputes regarding MAC pricing that includes: • A 15-business-day limit on the right to appeal following the initial claim; • A requirement that the appeal be investigated and resolved within seven business days after the appeal is received; and • A requirement that a PBM provide a reason for any appeal denial and identify the NDC of a drug that may be purchased by the pharmacy at a price at or below the MAC price as determined by the PBM. If an appeal is upheld, the PBM must make an adjustment to the MAC price no later than 1 business day after the date of determination. The PBM must make the price adjustment applicable to all similarly situated network pharmacy providers as defined by the plan sponsor.	

Patient Cost-Sharing	**Maximum Cost-Sharing Levels:** No PBM or health carrier shall require an enrollee to make a payment at the point of sale for a covered prescription drug in an amount greater than the lesser of: • The applicable co-payment for the prescription drug; • The allowable claim amount for the prescription drug; or • The amount an enrollee would pay for the prescription drug if the enrollee purchased the prescription drug without using a health plan or any other source of prescription drug benefits or discounts. **Copay Cap:** A health plan must limit the amount of any enrollee cost-sharing for prescription drugs prescribed to treat a chronic disease to no more than: (1) $25 per one-month supply for each prescription drug, regardless of the amount or type of medication required to fill the prescription; and (2) $50 per month in total for all related medical supplies. The cost-sharing limit for related medical supplies does not increase with the number of chronic diseases for which an enrollee is treated. Coverage under this section shall not be subject to any deductible. The chronic diseases covered under this provision include diabetes, asthma, and allergies requiring an epinephrine auto-injector.	MRS § 62W.12; MRS § 62Q.481