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State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-THIRD SESSION

H. F. No. 3268

04/19/2023 Authored by Bahner, Elkins, Her, Reyer, Bierman and others
The bill was read for the first time and referred to the Committee on Commerce Finance and Policy

1.1 A bill for an act
1.2 relating to insurance; requiring a prior authorization report; proposing coding for
1.3 new law in Minnesota Statutes, chapter 62M.

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

1.5 Section 1. [62M.19] PRIOR AUTHORIZATION REPORT.

1.6 (a) On or before September 1 each year, a utilization review organization must annually
1.7 report to the commissioner of commerce, on a form and in a manner specified by the
1.8 commissioner of commerce, information regarding prior authorization requests for the
1.9 previous calendar year. The report submitted under this paragraph must include:

1.10 (1) the number total of prior authorization requests received for the year for the following
1.11 category of services:

- 1.12 (i) medical procedures;
1.13 (ii) diagnostic tests and diagnostic images;
1.14 (iii) prescription medications; and
1.15 (iv) other;

1.16 (2) the number of prior authorizations for which an authorization was approved for each
1.17 category under clause (1);

1.18 (3) the number of prior authorization requests for which an adverse determination was
1.19 issued and the service was denied for each category under clause (1);

1.20 (4) the number of adverse determinations that were appealed, and whether the adverse
1.21 determination was upheld or reversed on appeal, for each category under clause (1); and

2.1 (5) the reasons for prior authorization denial, including but not limited to:

2.2 (i) the patient did not meet prior authorization criteria;

2.3 (ii) incomplete information was submitted by the provider to the utilization review
2.4 organization;

2.5 (iii) the treatment program changed; or

2.6 (iv) the patient is no longer covered by the plan.

2.7 (b) The commissioner of commerce must report to the legislature no later than February
2.8 15, 2024, regarding the practices of utilization review organizations related to the use of
2.9 prior authorization. The report must include the total number of prior authorizations:

2.10 (1) requested;

2.11 (2) approved without the need for an appeal;

2.12 (3) denied; and

2.13 (4) approved after an appeal.

2.14 (c) The commissioner of commerce must analyze the submitted data and issue a report
2.15 on the use of utilization management tools, including prior authorization, and the effect
2.16 utilization management tools have on patient access to care, the administrative burden on
2.17 health care providers, and system cost. When developing the report, the commissioner must
2.18 consult with, as appropriate, health care providers, insurers, consumers, and other health
2.19 care experts. The report must include but is not limited to recommendations regarding how
2.20 to:

2.21 (1) simplify health insurance prior authorization standards and processes to improve
2.22 health care access and reduce the burden on health care providers;

2.23 (2) maximize health care access and quality of care; and

2.24 (3) focus utilization review tools on services that the commissioner of commerce
2.25 determines are overutilized.

2.26 (d) If the commissioner determines that, with respect to a service described in paragraph
2.27 (a) that currently requires prior authorization, the utilization review organization is approving
2.28 at least 80 percent of the prior authorization requests for the service, the commissioner must
2.29 include in the recommendations made under paragraph (c) an additional recommendation
2.30 to prohibit prior authorization for the service receiving at least 80 percent approval for
2.31 services provided on or after August 1, 2024.