SENATE
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S.F. No. 3532

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02/12/2024	11553	Introduction and first reading Referred to Commerce and Consumer Protection
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A bill for an act

relating to health care; modifying requirements for prior authorization and coverage of health care services; modifying a ground for disciplinary action against physicians; requiring reports to the commissioner of commerce and a report to the legislature; classifying data; authorizing rulemaking; amending Minnesota Statutes 2022, sections 62M.01, subdivision 3; 62M.02, subdivision 1a; 62M.05, subdivision 3a, by adding a subdivision; 62M.07, subdivision 2, by adding a subdivision; 62M.17, subdivision 2; 147.091, subdivision 1b; proposing coding for new law in Minnesota Statutes, chapters 62A; 62M; repealing Minnesota Statutes 2022, section 62D.12, subdivision 19.

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

Section 1. **[62A.59] COVERAGE OF SERVICE; PRIOR AUTHORIZATION.**

Subdivision 1. **Service for which prior authorization not required.** A health carrier must not retrospectively deny or limit coverage of a health care service for which prior authorization was not required by the health carrier, unless there is evidence that the health care service was provided based on fraud or misinformation.

Subd. 2. **Service for which prior authorization required but not obtained.** A health carrier must not deny or limit coverage of a health care service which the enrollee has already received solely on the basis of lack of prior authorization if the service would otherwise have been covered had the prior authorization been obtained.

Sec. 2. Minnesota Statutes 2022, section 62M.01, subdivision 3, is amended to read:

Subd. 3. **Scope.** (a) Nothing in this chapter applies to review of claims after submission to determine eligibility for benefits under a health benefit plan. The appeal procedure

described in section 62M.06 applies to any complaint as defined under section 62Q.68, subdivision 2, that requires a medical determination in its resolution.

(b) This chapter ~~does not apply~~ applies to managed care plans ~~or~~ and county-based purchasing plans when the plan is providing coverage to state public health care program enrollees under chapter 256B or 256L.

Sec. 3. Minnesota Statutes 2022, section 62M.02, subdivision 1a, is amended to read:

Subd. 1a. **Adverse determination.** "Adverse determination" means a decision by a utilization review organization relating to an admission, extension of stay, or health care service that is partially or wholly adverse to the enrollee, including: (1) a decision to deny an admission, extension of stay, or health care service on the basis that it is not medically necessary; or (2) an authorization for a health care service that is less intensive than the health care service specified in the original request for authorization.

Sec. 4. Minnesota Statutes 2022, section 62M.05, subdivision 3a, is amended to read:

Subd. 3a. **Standard review determination.** (a) ~~Notwithstanding subdivision 3b, a standard review determination on all requests for utilization review must be communicated to the provider and enrollee in accordance with this subdivision within five business days after receiving the request if the request is received electronically, or within six business days if received through nonelectronic means, provided that all information reasonably necessary to make a determination on the request has been made available to the utilization review organization. Effective January 1, 2022,~~ A standard review determination on all requests for utilization review must be communicated to the provider and enrollee in accordance with this subdivision within five business days after receiving the request, regardless of how the request was received, provided that all information reasonably necessary to make a determination on the request has been made available to the utilization review organization.

(b) When a determination is made to authorize, notification must be provided promptly by telephone to the provider. The utilization review organization shall send written notification to the provider or shall maintain an audit trail of the determination and telephone notification. For purposes of this subdivision, "audit trail" includes documentation of the telephone notification, including the date; the name of the person spoken to; the enrollee; the service, procedure, or admission authorized; and the date of the service, procedure, or admission. If the utilization review organization indicates authorization by use of a number, the number must be called the "authorization number." For purposes of this subdivision,

notification may also be made by facsimile to a verified number or by electronic mail to a secure electronic mailbox. These electronic forms of notification satisfy the "audit trail" requirement of this paragraph.

(c) When an adverse determination is made, notification must be provided within the time periods specified in paragraph (a) by telephone, by facsimile to a verified number, or by electronic mail to a secure electronic mailbox to the attending health care professional and hospital or physician office as applicable. Written notification must also be sent to the hospital or physician office as applicable and attending health care professional if notification occurred by telephone. For purposes of this subdivision, notification may be made by facsimile to a verified number or by electronic mail to a secure electronic mailbox. Written notification must be sent to the enrollee and may be sent by United States mail, facsimile to a verified number, or by electronic mail to a secure mailbox. The written notification must include all reasons relied on by the utilization review organization for the determination and the process for initiating an appeal of the determination. Upon request, the utilization review organization shall provide the provider or enrollee with the criteria used to determine the necessity, appropriateness, and efficacy of the health care service and identify the database, professional treatment parameter, or other basis for the criteria. Reasons for an adverse determination may include, among other things, the lack of adequate information to authorize after a reasonable attempt has been made to contact the provider or enrollee.

(d) When an adverse determination is made, the written notification must inform the enrollee and the attending health care professional of the right to submit an appeal to the internal appeal process described in section 62M.06 and the procedure for initiating the internal appeal. The written notice shall be provided in a culturally and linguistically appropriate manner consistent with the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a.

Sec. 5. Minnesota Statutes 2022, section 62M.05, is amended by adding a subdivision to read:

Subd. 6. **Automated process.** A utilization review organization must establish and maintain a prior authorization application programming interface that automates certain elements of the prior authorization process for in-network providers and facilitates the exchange of information between providers and utilization review organizations. The application programming interface must:

(1) automate the process used to determine whether prior authorization is required for durable medical equipment, a health care service, or a prescription drug;

(2) allow providers to query a health plan company's prior authorization information and documentation requirements;

(3) support an automated approach using nonproprietary, open workflows to compile and exchange the necessary data elements to populate a prior authorization request and to facilitate the exchange of prior authorization requests and determinations with provider electronic health records and practice management systems. These activities must comply with the federal Health Insurance Portability and Accountability Act of 1996, as amended, and regulations adopted under that act or with an exception to the act and regulations from the federal Centers for Medicare and Medicaid Services; and

(4) indicate that a prior authorization denial or an authorization for a health care service less intensive than the health care service specified in the original request for authorization constitutes an adverse determination and may be appealed under section 62M.06.

Sec. 6. Minnesota Statutes 2022, section 62M.07, subdivision 2, is amended to read:

Subd. 2. **Prior authorization of ~~emergency~~ certain services prohibited.** No utilization review organization, health plan company, or claims administrator may conduct or require prior authorization of:

(1) emergency confinement or an emergency service. The enrollee or the enrollee's authorized representative may be required to notify the health plan company, claims administrator, or utilization review organization as soon as reasonably possible after the beginning of the emergency confinement or emergency service.;

(2) medication to treat a substance use disorder;

(3) a generic drug or multisource brand name drug rated as therapeutically equivalent according to the FDA Orange Book or a biologic drug rated as interchangeable according to the FDA Purple Book;

(4) outpatient mental health treatment or outpatient substance use disorder treatment;

(5) antineoplastic cancer treatment that is consistent with guidelines of the National Comprehensive Cancer Network;

(6) services that currently have a rating of A or B from the United States Preventive Services Task Force, immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or preventive services and screenings provided to women as described in Code of Federal Regulations, title 45, section 147.130;

(7) pediatric hospice services provided by a hospice provider licensed under sections 144A.75 to 144A.755;

(8) treatment delivered through a neonatal abstinence program operated by pediatric pain or palliative care subspecialists; and

(9) services covered through a value-based arrangement that:

(i) ties a payment for the provision of health care services to the quality of health care provided;

(ii) rewards a provider for efficiency and effectiveness; and

(iii) imposes a risk-sharing requirement on the provider for health care services that do not meet the health plan company's requirements for quality, effectiveness, and efficiency.

Sec. 7. Minnesota Statutes 2022, section 62M.07, is amended by adding a subdivision to read:

Subd. 5. **Treatment of a chronic condition.** An authorization for treatment of a health condition that an enrollee is expected to have for longer than one year does not expire unless the standard of treatment for that health condition changes.

Sec. 8. **[62M.075] REQUIREMENTS FOR PRIOR AUTHORIZATION EXEMPTION PROCESS; RULEMAKING.**

Subdivision 1. **Prior authorization exemption process.** (a) By January 1, 2025, the commissioner of commerce must adopt rules establishing requirements for a prior authorization exemption process to exempt providers or groups of providers from prior authorization requirements. The exemption process must:

(1) include a percentile-based eligibility threshold in which a provider or group of providers is exempt from prior authorization requirements if the provider or group of providers has an authorization rate in the 70th percentile or greater for all submitted requests for authorization;

(2) apply to individual services and, to the extent possible, groups of services;

(3) be based on the actual authorization experience of providers or groups of providers over the most recent 12-month period;

(4) provide that exemptions are valid for at least 12 months from the date of the exemption determination;

(5) provide that exemptions are renewable for additional 12-month periods based on a reasonable statistical sample of services provided during the exemption period;

(6) include a process by which providers or groups of providers may appeal exemption determinations. The appeals process must allow providers to access the underlying data used by the utilization review organization to determine eligibility for the exemption; and

(7) reduce, to the greatest extent possible, the administrative burden prior authorization requirements place on providers and groups of providers.

(b) In adopting rules under this section, the commissioner must consult with stakeholders that include but are not limited to physicians, health plan companies, hospitals, clinic staff who process prior authorization requests, and utilization review organizations.

Subd. 2. **Expedited rulemaking process.** The commissioner may use the expedited rulemaking process in section 14.389 to adopt rules under this section.

Subd. 3. **Data.** Utilization review organizations, health plan companies, and claims administrators must provide the commissioner with any data needed by the commissioner to adopt rules under this section. Data provided to the commissioner under this subdivision is classified as private data on individuals as defined in section 13.02, subdivision 12, or nonpublic data as defined in section 13.02, subdivision 9.

Subd. 4. **Implementation.** By January 1, 2026, each utilization review organization must administer a prior authorization exemption process that complies with the requirements in rules adopted under this section.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 9. Minnesota Statutes 2022, section 62M.17, subdivision 2, is amended to read:

Subd. 2. **Effect of change in prior authorization clinical criteria.** (a) If, during a plan year, a utilization review organization changes coverage terms for a health care service or the clinical criteria used to conduct prior authorizations for a health care service, the change in coverage terms or change in clinical criteria shall not apply until the next plan year for any enrollee who received prior authorization for a health care service using the coverage terms or clinical criteria in effect before the effective date of the change.

(b) Paragraph (a) does not apply if a utilization review organization changes coverage terms for a drug or device that has been deemed unsafe by the United States Food and Drug Administration (FDA); that has been withdrawn by either the FDA or the product manufacturer; or when an independent source of research, clinical guidelines, or

evidence-based standards has issued drug- or device-specific warnings or recommended changes in drug or device usage.

(c) Paragraph (a) does not apply if a utilization review organization changes coverage terms for a service or the clinical criteria used to conduct prior authorizations for a service when an independent source of research, clinical guidelines, or evidence-based standards has recommended changes in usage of the service for reasons related to previously unknown and imminent patient harm.

(d) Paragraph (a) does not apply if a utilization review organization removes a brand name drug from its formulary or places a brand name drug in a benefit category that increases the enrollee's cost, provided the utilization review organization (1) adds to its formulary a generic or multisource brand name drug rated as therapeutically equivalent according to the FDA Orange Book, or a biologic drug rated as interchangeable according to the FDA Purple Book, at a lower cost to the enrollee, and (2) provides at least a 60-day notice to prescribers, pharmacists, and affected enrollees.

Sec. 10. **[62M.19] ANNUAL REPORT TO COMMISSIONER OF COMMERCE; PRIOR AUTHORIZATIONS.**

Subdivision 1. **Annual report; contents.** On or before September 1 each year, each utilization review organization must report to the commissioner of commerce, in a form and manner specified by the commissioner, information on prior authorization requests for the previous calendar year. The report submitted under this subdivision must include the following data, sorted by the categories of services listed in subdivision 2:

(1) the total number of prior authorization requests received;

(2) the number of prior authorization requests for which an authorization was issued;

(3) the number of prior authorization requests for which an adverse determination was issued;

(4) the number of adverse determinations reversed on appeal;

(5) the 25 codes with the highest number of prior authorization requests and the percentage of authorizations for each of these codes;

(6) the 25 codes with the highest percentage of prior authorization requests for which an authorization was issued and the total number of such requests;

(7) the 25 codes with the highest percentage of prior authorization requests for which an adverse determination was issued but which was reversed on appeal and the total number of such requests;

(8) the 25 codes with the highest percentage of prior authorization requests for which an adverse determination was issued and the total number of such requests; and

(9) the reasons an adverse determination to a prior authorization request was issued, expressed as a percentage of all adverse determinations for each category of services listed in subdivision 2. The reasons listed may include but are not limited to:

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

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

(iii) the treatment program changed; and

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

Subd. 2. **Categories of services.** The data submitted to the commissioner under subdivision 1 must be sorted by the following categories of services:

(1) inpatient medical and surgical services;

(2) outpatient medical and surgical services;

(3) inpatient mental health and substance use disorder services;

(4) outpatient mental health and substance use disorder services;

(5) diagnostic imaging services;

(6) diabetes supplies and equipment;

(7) durable medical equipment; and

(8) prescription drugs.

Sec. 11. Minnesota Statutes 2022, section 147.091, subdivision 1b, is amended to read:

Subd. 1b. **Utilization review.** The board may investigate allegations and impose disciplinary action as described in section 147.141 against a physician performing utilization review for ~~a pattern of~~ failure to apply current evidence when making a utilization review determination, or failure to exercise that degree of care that a physician reviewer of ordinary prudence making utilization review determinations for a utilization review organization would use under the same or similar circumstances. As part of its investigative process, the

board shall receive consultation or recommendation from physicians who are currently engaged in utilization review activities. The internal and external review processes under sections 62M.06 and 62Q.73 must be exhausted prior to an allegation being brought under this subdivision. Nothing in this subdivision creates, modifies, or changes existing law related to tort liability for medical negligence. Nothing in this subdivision preempts state peer review law protection in accordance with sections 145.61 to 145.67, federal peer review law, or current law pertaining to complaints or appeals.

Sec. 12. **COMMISSIONER OF COMMERCE; ANALYSIS AND REPORT TO THE LEGISLATURE.**

(a) The commissioner of commerce must use the data submitted by utilization review organizations under Minnesota Statutes, section 62M.19, and other data available to the commissioner to analyze the use of utilization management tools, including prior authorization, in health care. The analysis must evaluate the effect utilization management tools have on patient access to care, the administrative burden the use of utilization management tools places on health care providers, and system costs. The commissioner must also develop recommendations on how to simplify health insurance prior authorization standards and processes to improve health care access, reduce delays in care, reduce the administrative burden on health care providers, and maximize quality of care. When conducting the analysis and developing recommendations, the commissioner must consult, as appropriate, with physicians, other providers, health plan companies, consumers, and other health care experts.

(b) The commissioner must issue a report to the legislature by January 15, 2026, containing the commissioner's analysis and recommendations under paragraph (a).

Sec. 13. **INITIAL REPORTS TO COMMISSIONER OF COMMERCE; UTILIZATION MANAGEMENT TOOLS.**

Utilization review organizations must submit initial reports to the commissioner of commerce under Minnesota Statutes, section 62M.19, by September 1, 2025.

Sec. 14. **REPEALER.**

Minnesota Statutes 2022, section 62D.12, subdivision 19, is repealed.

62D.12 PROHIBITED PRACTICES.

Subd. 19. **Coverage of service.** A health maintenance organization may not deny or limit coverage of a service which the enrollee has already received solely on the basis of lack of prior authorization or second opinion, to the extent that the service would otherwise have been covered under the member's contract by the health maintenance organization had prior authorization or second opinion been obtained.