SENATE
STATE OF MINNESOTA
NINETY-FIRST SESSION

S.F. No. 3077

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DATE	D-PG	OFFICIAL STATUS
02/13/2020	4747	Introduction and first reading Referred to Health and Human Services Finance and Policy

A bill for an act

relating to health insurance; specifying limits to prior authorization requirements for prescription drugs if certain circumstances are met; amending Minnesota Statutes 2018, section 62M.07.

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

Section 1. Minnesota Statutes 2018, section 62M.07, is amended to read:

62M.07 PRIOR AUTHORIZATION OF SERVICES.

(a) Utilization review organizations conducting prior authorization of services must have written standards that meet at a minimum the following requirements:

(1) written procedures and criteria used to determine whether care is appropriate, reasonable, or medically necessary;

(2) a system for providing prompt notification of its determinations to enrollees and providers and for notifying the provider, enrollee, or enrollee's designee of appeal procedures under clause (4);

(3) compliance with section 62M.05, subdivisions 3a and 3b, regarding time frames for approving and disapproving prior authorization requests;

(4) written procedures for appeals of denials of prior authorization which specify the responsibilities of the enrollee and provider, and which meet the requirements of sections 62M.06 and 72A.285, regarding release of summary review findings; and

(5) procedures to ensure confidentiality of patient-specific information, consistent with applicable law.

(b) No utilization review organization, health plan company, or claims administrator may conduct or require prior authorization of emergency confinement or emergency treatment. 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 after the beginning of the emergency confinement or emergency treatment as reasonably possible.

(c) No utilization review organization, health plan company, claims administrator, or pharmacy benefit manager may conduct or require prior authorization for a prescribed drug if:

(1) the enrollee has obtained an initial prior authorization from the utilization organization, health plan company, claims administrator, or pharmacy benefit manager for the prescribed drug;

(2) the enrollee has maintained continuous enrollment in the same health benefit plan since receiving the initial prior authorization;

(3) the enrollee has been prescribed the same drug at the same dosage on a monthly basis for at least ten consecutive months; and

(4) the enrollee's condition that has necessitated the prescribed drug remains stable.

Nothing in this paragraph requires a health plan company to provide coverage for a prescription drug that is not covered under the enrollee's health plan or the health plan's drug formulary.

(d) If prior authorization for a health care service is required, the utilization review organization, health plan company, or claim administrator must allow providers to submit requests for prior authorization of the health care services without unreasonable delay by telephone, facsimile, or voice mail or through an electronic mechanism 24 hours a day, seven days a week. This paragraph does not apply to dental service covered under MinnesotaCare or medical assistance.