SENATE
STATE OF MINNESOTA
NINETY-THIRD SESSION

S.F. No. 2331

(SENATE AUTHORS: MORRISON)

DATE	D-PG	OFFICIAL STATUS
03/01/2023		Introduction and first reading Referred to Commerce and Consumer Protection

A bill for an act

relating to insurance; requiring a prior authorization report; proposing coding for new law in Minnesota Statutes, chapter 62M.

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

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

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

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

(i) medical procedures;

(ii) diagnostic tests and diagnostic images;

(iii) prescription medications; and

(iv) other;

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

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

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

(5) the reasons for prior authorization denial, including but 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; or

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

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

(1) requested;

(2) approved without the need for an appeal;

(3) denied; and

(4) approved after an appeal.

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

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

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

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

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