HF3398/SF3204
Streamlining the Prior Authorization Process

Reducing delays in patient care & administrative burden for providers.

Patients across Minnesota are having their care unreasonably delayed or are paying out of pocket due to waiting for their health insurer to approve payment for a procedure or medication that has been prescribed or ordered by their physician and is part of their current covered benefit set.

HF3398/SF3204 updates existing state prior authorization laws to include reasonable criteria to better define the prior authorization process. The updates will help patients by reducing delays in care, as well as decreasing physician frustration and administrative expenses associated with the current cumbersome prior authorization process. Prior authorization often adds significant expense to clinics and hospitals while compromising patient care.

Protecting patient access to timely care:

- Prior authorization determinations to be made in 5 business days instead of 10 business days. The bill maintains the current time requirement of 72 hours for expedited prior authorization determinations but accelerates the timeframe to 48 hours effective in 2022. This is a goal set by both national providers and national payers.
- Standard appeals of prior authorization denials must be made within 15 days instead of up to 30 business days.
- If a patient changes health insurance plans, the new plan will cover existing prior authorizations from the previous plan for 60 days to allow for a safe transition to a new treatment plan.
- A health insurance plan will not be able to change coverage terms or clinical criteria during the plan year for patients who have an approved prior authorization.

Creating a more efficient, transparent prior authorization process:

- A Minnesota-licensed physician who has experience treating patients with the illness, injury, or disease for which the health care procedure or diagnostic test has been requested will decide the prior authorization.
- The health plan company will post on its public website the prior authorization requirements and restrictions in detailed and easily understandable language.
- The health insurance plan will give at least 45 days before any changes or new prior authorization requirement or restrictions are implemented.
- Insurers will be required to report the number of approved prior authorizations, denials, and other critical information to better guide consumers and policy makers.

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Specialty Healthcare


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Multiple Sclerosis
Society


Children's
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MGMA
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Healthcare


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CITIZENS WITH
DISABILITIES


MPMA
Minnesota Podiatric
Medical Association


CDI
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ACOG
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Obstetricians and Gynecologists


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