This Document can be made available
in alternative formats upon request

State of Minnesota
HOUSE OF REPRESENTATIVES

NINETY-FOURTH SESSION

H. F. No. 4801

04/07/2026 Authored by Nadeau
The bill was read for the first time and referred to the Committee on Health Finance and Policy

A bill for an act

relating to health care; modifying provisions governing prior authorization of health care services; modifying managed care contracts under medical assistance; amending Minnesota Statutes 2024, sections 62A.59, subdivisions 1, 2; 62M.07, subdivisions 2, 5, by adding a subdivision; 256B.69, subdivision 37, by adding a subdivision; 256B.6928, subdivision 4.

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

Section 1. Minnesota Statutes 2024, section 62A.59, subdivision 1, is amended to read:

Subdivision 1. **Service for which prior authorization not required.** A health ~~carrier~~ plan must not retrospectively deny or limit coverage of a health care service for which prior authorization was not required by the health ~~carrier~~ plan, unless the denial or limitation is based on the health plan's established medical policy, contractual limits, or exclusions, or there is evidence that the health care service was provided based on fraud or misinformation.

EFFECTIVE DATE. This section is effective January 1, 2027, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 2. Minnesota Statutes 2024, section 62A.59, subdivision 2, is amended to read:

Subd. 2. **Service for which prior authorization required but not obtained.** A health ~~carrier~~ plan 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.

EFFECTIVE DATE. This section is effective January 1, 2027, and applies to health plans offered, sold, or renewed on or after that date.

Sec. 3. Minnesota Statutes 2024, section 62M.07, subdivision 2, is amended to read:

Subd. 2. **Prior authorization of 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) outpatient mental health treatment or outpatient substance use disorder treatment, except for treatment which is a medication. Prior authorizations required for medications used for outpatient mental health treatment or outpatient substance use disorder treatment must be processed according to section 62M.05, subdivision 3b, for initial determinations, and according to section 62M.06, subdivision 2, for appeals;

(3) antineoplastic cancer treatment that is consistent with guidelines of the National Comprehensive Cancer Network, except for treatment which is a medication. Prior authorizations required for medications used for antineoplastic cancer treatment must be processed according to section 62M.05, subdivision 3b, for initial determinations, and according to section 62M.06, subdivision 2, for appeals;

(4) 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;

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

(6) treatment delivered through a neonatal abstinence program operated by pediatric pain or palliative care subspecialists.

~~Clauses (2) to (6) are effective January 1, 2026, and apply to health benefit plans offered, sold, issued, or renewed on or after that date.~~ Nothing in this subdivision prohibits a utilization review organization, health plan company, or claims administrator from conducting or requiring prior authorization for services if the number, duration, scope, or other factor of the services to be provided exceeds the standard of treatment.

EFFECTIVE DATE. This section is effective January 1, 2027, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 4. Minnesota Statutes 2024, section 62M.07, subdivision 5, is amended to read:

Subd. 5. **Treatment of a chronic condition.** ~~This subdivision is effective January 1, 2026, and applies to health benefit plans offered, sold, issued, or renewed on or after that date.~~ (a) An authorization for ongoing treatment of a chronic health condition does not expire before the end of the current standard of treatment time frame unless:

(1) the standard of treatment for that health condition changes~~.~~;

(2) the enrollee's health condition no longer meets the criteria in paragraph (b) for a chronic health condition; or

(3) the enrollee's health condition has changed such that the authorized treatment no longer meets the standard of care for that particular health condition.

(b) A chronic health condition is a condition that is expected to last one year or more and:

(1) requires ongoing medical attention to effectively manage the condition or prevent an adverse health event; or

(2) limits one or more activities of daily living.

(c) Nothing in this subdivision prohibits a utilization review organization, health plan company, or claims administrator from requiring an enrollee to provide documentation confirming that the enrollee's health condition continues to be a chronic health condition.

EFFECTIVE DATE. This section is effective January 1, 2027, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 5. Minnesota Statutes 2024, section 62M.07, is amended by adding a subdivision to read:

Subd. 6. **Identification of conflicting services.** Nothing in law prohibits a utilization review organization, health plan company, or claims administrator from requiring prior authorization for services the utilization review organization, health plan company, or claims administrator identifies as conflicting services. For purposes of this subdivision, conflicting services include but are not limited to services that:

(1) are provided simultaneously, in close proximity in time, or within a time frame that is in conflict with the standard of care; and

4.1 (2) have the potential to create an adverse outcome for the enrollee.

4.2 **EFFECTIVE DATE.** This section is effective January 1, 2027, and applies to health
4.3 plans offered, sold, issued, or renewed on or after that date.

4.4 Sec. 6. Minnesota Statutes 2024, section 256B.69, is amended by adding a subdivision to
4.5 read:

4.6 Subd. 10a. **Data sharing for program integrity.** If the commissioner receives a written
4.7 report from a managed care plan that has reason to believe that a provider, vendor, managed
4.8 care employee, subcontractor, or enrollee committed fraud under this chapter or chapter
4.9 256L, the commissioner must provide summary data, as defined in section 13.02, subdivision
4.10 19, from the report to other managed care plans contracted under this section within ten
4.11 days of receiving the report. Nothing in this subdivision allows release of information that
4.12 is nonpublic data pursuant to section 13.02, subdivision 9.

4.13 Sec. 7. Minnesota Statutes 2024, section 256B.69, subdivision 37, is amended to read:

4.14 Subd. 37. **Networks.** (a) The commissioner shall ensure that a managed care
4.15 organization's network providers are enrolled with the commissioner as medical assistance
4.16 providers, and that the providers comply with the provider disclosure, screening, and
4.17 enrollment requirements in Code of Federal Regulations, part 42, section 455. A provider
4.18 that has a network provider contract with the managed care organization is not required to
4.19 provide services to a medical assistance or MinnesotaCare recipient who is receiving services
4.20 through the fee-for-service system.

4.21 (b) A managed care organization may enter into a network provider contract with a
4.22 provider that is not a medical assistance provider for a period of up to 120 days pending the
4.23 outcome of the medical assistance provider enrollment process. A managed care organization
4.24 must terminate the contract upon notification that the provider cannot be enrolled as a
4.25 medical assistance provider or upon expiration of the 120-day period if notification has not
4.26 been received within that period. The managed care organization must notify each affected
4.27 enrollee of the provider contract termination.

4.28 (c) For purposes of this subdivision, "network provider" means any provider, group of
4.29 providers, entity with a network provider agreement with the managed care organization,
4.30 or subcontractor that receives payments from the managed care organization either directly
4.31 or indirectly to provide services under a managed care contract between the commissioner
4.32 and the managed care organization.

5.1 (d) A managed care organization is not required to include a provider in its network
5.2 before approving the provider's credentials in accordance with section 62Q.097.

5.3 **EFFECTIVE DATE.** This section is effective January 1, 2027.

5.4 Sec. 8. Minnesota Statutes 2024, section 256B.6928, subdivision 4, is amended to read:

5.5 Subd. 4. **Special contract requirements related to payment.** (a) If the commissioner
5.6 uses risk-sharing mechanisms, including reinsurance~~, risk corridors,~~ or stop-loss limits, the
5.7 risk-sharing mechanism must be described in the contract, and must be developed according
5.8 to the rate development standards and generally accepted actuarial principles and practices.

5.9 (b) The commissioner must include risk corridors in managed care organization contracts.
5.10 The risk corridors must be symmetrical, two-sided, and uniform for all managed care
5.11 organizations under contract with the commissioner and include a settle-up process that
5.12 occurs within six months of the end of the plan year.

5.13 ~~(b)~~ (c) The commissioner may utilize incentive payment arrangements in managed care
5.14 organization contracts. Any incentive arrangement utilized by the commissioner must be
5.15 made available to all managed care organizations under contract with the commissioner
5.16 under the same terms of performance. The payment must not exceed 105 percent of the
5.17 approved capitation payments attributable to the enrollees or services covered by the incentive
5.18 arrangement and must be actuarially sound. For all incentive arrangements the contract
5.19 must state that the arrangement is:

5.20 (1) for a fixed period of time and performance is measured during the rating period in
5.21 which the incentive arrangement is applied;

5.22 (2) not renewed automatically; and

5.23 (3) associated with specified activities, targets, performance measures, or quality-based
5.24 outcomes in the quality strategy described under section 256B.6927.

5.25 The incentive payment arrangement must not condition a managed care organization's
5.26 participation in the incentive arrangement upon entering into or adhering to an
5.27 intergovernmental transfer agreement.

5.28 ~~(c)~~ (d) The commissioner may utilize withhold arrangements in managed care
5.29 organization contracts. Any withhold arrangement utilized by the commissioner must be
5.30 applied to all managed care organizations under contract with the commissioner under the
5.31 same terms of performance. Any withhold arrangement must ensure that the capitation
5.32 payment minus any portion of the withheld funds that is not reasonably achievable is

6.1 actuarially sound. The total amount of the withheld funds, achievable or not, must be
6.2 reasonable and must take into consideration each managed care organization's financial
6.3 operating needs, accounting for the size and characteristics of the populations covered under
6.4 the contract, as well as the managed care organization's capital reserves, as measured by
6.5 the risk based capital level, months of claims reserve, or other appropriate measure of
6.6 reserves. The data, assumptions, and methodologies used to determine the portion of the
6.7 withhold that is reasonably achievable must be submitted as part of the documentation
6.8 required by Code of Federal Regulations, part 42, section 438.7, paragraph (b), clause (6).
6.9 For all withhold arrangements, the contract must state that the arrangement is:

6.10 (1) for a fixed period of time and performance is measured during the rating period in
6.11 which the withhold arrangement is applied;

6.12 (2) not renewed automatically; and

6.13 (3) associated with specified activities, targets, performance measures, or quality-based
6.14 outcomes in the state's quality strategy.

6.15 The withhold payment arrangement must not condition a managed care organization's
6.16 participation in the withhold arrangement upon entering into or adhering to an
6.17 intergovernmental transfer agreement.

6.18 **EFFECTIVE DATE.** This section is effective January 1, 2027.