Bill Summary

H.F. 3578

First engrossment, as amended by H3578A5

Subject	Prior authorization of health care services
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Overview

Prior authorization is the evaluation by a person other than the attending health care professional, before the delivery of a health care service, of the service's necessity, appropriateness, and efficacy, to determine the medical necessity of the service for a patient. This bill modifies requirements for utilization review and prior authorization of health care services, including requiring utilization review organizations to automate elements of the prior authorization process and specifying additional services for which prior authorization cannot be conducted or required. Additionally, it requires data on prior authorizations to be reported to the commissioner of commerce on an annual basis, and requires a report to the legislature. This bill also prohibits health carriers from retrospectively limiting coverage of a health care service in certain circumstances.

Summary

Section	Description
1	**Coverage of service; prior authorization.** Adds § 62A.59. Prohibits a health carrier from: ▪ retrospectively denying or limiting coverage of a service for which prior authorization was not required, unless there is evidence the service was provided based on fraud or misinformation; and ▪ denying or limiting coverage of a service the enrollee already received on the basis of lack of prior authorization, if the service would have been covered if prior authorization had been obtained. Effective date: This section is effective January 1, 2026, and applies to health plans offered, sold, issued, or renewed on or after that date.
2	**Coverage of service.** Amends § 62D.12, subd. 19. Provides this subdivision expires December 31, 2025, for health plans offered, sold, issued, or renewed on or after that date. (This subdivision

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	prohibits a health maintenance organization from denying or limiting coverage already received solely based on lack of prior authorization or second opinion, if the service would have been covered had the prior authorization or second opinion been obtained. This subdivision is being replaced by section 62A.59, subd. 2.)
3	**Scope.** Amends § 62M.01, subd. 3. Provides that effective January 1, 2026, chapter 62M, which governs utilization review of health care, applies to medical assistance fee-for-service and to managed care plans and county-based purchasing plans covering medical assistance or MinnesotaCare enrollees. (Current law provides chapter 62M does not apply to managed care plans and county-based purchasing plans covering medical assistance or MinnesotaCare enrollees).
4	**Adverse determination.** Amends § 62M.02, subd. 1a. Amends the definition of adverse determination to provide adverse determination includes an authorization for a health care service that is less intensive than the health care service specified in the original authorization request. Effective date: This section is effective the day following final enactment.
5	**Standard review determination.** Amends § 62M.05, subd. 3a. Strikes obsolete language from a paragraph establishing timelines for communicating standard review determinations to providers and enrollees. Effective date: This section is effective the day following final enactment.
6	**Automated process.** Adds subd. 6 to § 62M.05. Requires utilization review organizations to establish a prior authorization application programming interface to automate certain steps of the prior authorization process and promote information exchange between providers and utilization review organizations. Lists functions the application programming interface must perform. Provides this subdivision is effective January 1, 2026, and applies to health plans offered, sold, issued, or renewed on or after that date.
7	**Prior authorization of certain services prohibited.** Amends § 62M.07, subd. 2. Current law prohibits prior authorization from being conducted or required for emergency confinement or an emergency service. This section adds the following to the items for which prior authorization cannot be conducted or required:

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- medication to treat a substance use disorder;
- a generic drug or multisource brand name drug rated as therapeutically equivalent, a biologic drug rated as interchangeable, or a biosimilar;
- outpatient mental health or substance use disorder treatment;
- antineoplastic cancer treatment consistent with certain guidelines;
- certain preventive services, immunizations, and screenings;
- certain pediatric hospice services; and
- treatment provided by a neonatal abstinence program.

Provides clauses (2) to (8) are effective January 1, 2026, and apply to health plans offered, sold, issued, or renewed on or after that date.

8 **Treatment of a chronic condition.**

Adds subd. 5 to § 62M.07. Provides an authorization for treatment of a chronic health condition an enrollee is expected to have for longer than one year and that requires ongoing treatment does not expire unless the treatment standard for that chronic condition changes. Provides this subdivision is effective January 1, 2026, and applies to health plans offered, sold, issued, or renewed on or after that date.

9 **Value-based contracts.**

Adds subd. 6 to § 62M.07. Provides a utilization review organization, health plan company, or claims administrator must not conduct or require prior authorization for services reimbursed through a value-based contract that meets the listed criteria. Provides this subdivision is effective January 1, 2026, and applies to health plans offered, sold, issued, or renewed on or after that date.

10 **Effect of change in prior authorization clinical criteria.**

Amends § 62M.17, subd. 2. Under current law, a utilization review organization's change to coverage of a health care service or to the clinical criteria used for prior authorizations does not apply until the next plan year, for enrollees who received prior authorization for that service using the prior coverage terms or clinical criteria. This general rule does not apply if the utilization review organization changed coverage terms or the clinical criteria when an independent source recommended the change for reasons related to patient harm. A new paragraph (d) specifies the patient harm must be previously unknown and imminent for the exception to apply; paragraph (d) is effective January 1, 2026, and applies to health plans offered, sold, issued, or renewed on or after that date.

11 **Annual report to commissioner of commerce; prior authorizations.**

Adds § 62M.19. By September 1 each year, requires utilization review organizations to report to the commissioner of commerce, information on prior authorization

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requests for the previous calendar year. Lists data that must be included in each report, and requires this data to be sorted by the listed categories of services.

12 **Utilization review.**

Amends § 147.091, subd. 1b. Modifies Board of Medical Practice authority to investigate and impose disciplinary action against physicians for utilization review activities, to allow investigations and imposition of disciplinary action if a physician performing utilization review:

- fails to apply current evidence when making a utilization review determination; or
- fails to exercise the required degree of care in making utilization review determinations (current law allows investigations and imposition of disciplinary action for a pattern of failing to exercise the required degree of care).

Effective date: This section is effective the day following final enactment.

13 **Commissioner of commerce; analysis and report to the legislature.**

Requires the commissioner of commerce to use the data submitted by utilization review organizations and other available data to analyze the use of utilization management tools in health care. Lists what the analysis must include, and requires the commissioner to develop recommendations on how to simplify prior authorization standards and processes, including recommendations for a prior authorization exemption process for certain providers and group practices. Requires the commissioner to submit the analysis and recommendations to the legislature by December 15, 2026.

14 **Initial reports to commissioner of commerce; utilization management tools.**

Requires utilization review organizations to submit initial reports on prior authorizations during the previous calendar year by September 1, 2025.

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