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BILL SUMMARY

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S.F. No. 3532 – Prior Authorization (as amended by the A-3 amendment)

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Section 1 [62A.59] Coverage of Service; Prior Authorization. A health carrier must not deny or limit coverage for a health care service that prior authorization was not required. A health carrier must not deny or limit coverage for a health care service that an enrollee has already received on the basis of lack of prior authorization when it would have been covered if prior authorization had been obtained.

Section 2 (section 62D.12, subdivision 19). The current provision prohibiting health maintenance organizations from denying or limiting coverage of service on the basis of lack of prior authorization that would have been covered with prior authorization expires on December 31, 2025.

Section 3 (section 62M.01, subdivision 3). Effective January 1, 2026, chapter 62M applies to fee-for-service, managed care plans, and county-based purchasing plans.

Section 4 (section 62M.02, subdivision 1a). Adverse determination may mean an authorization for a health care service that is less intensive than the health care service specified in the original request for authorization.

Section 5 (section 62M.05, subdivision 3a). Standard review determinations on all requests for authorization need to be communicated to the provider and enrollee within five business days.

Section 6 (section 62M.05). Utilization review organizations must establish and maintain a prior authorization application program that automates the prior authorization process for in-network providers and facilitates the exchange of information between providers and utilization review organizations.

Section 7 (section 62M.07, subdivision 2). Prior authorization for the following services is prohibited:

1. Emergency confinement or emergency services;
2. Medication to treat a substance use disorder;
3. A generic drug or multisource brand name that is rated therapeutically equivalent;
4. Outpatient mental health treatment or outpatient substance use disorder treatment;
5. Antineoplastic cancer treatment;
6. Services that have a rating of A or B from the United States Preventive Services Task Force, certain immunizations, or preventive services and screenings provided to women;
7. Pediatric hospice services;
8. Treatment delivered through a neonatal abstinence program; and
9. Services covered through a value-based arrangement.

Section 8 (section 62M.07). An authorization for treatment of a chronic health condition does not expire unless the standard of treatment for the health condition changes.

Section 9 (section 62M.07). Prior authorization may not be required for services that are reimbursed through a value-based contract.

Section 10 (section 62M.17, subdivision 2). Effective January 1, 2026, the requirement that a change in coverage terms or change in clinical criteria shall not apply until the next plan year, does not apply if the changes were recommended by an independent source of research, clinical guidelines, or evidence-based standards.

Section 11 [62M.19] Annual Report to Commissioner of Commerce; Prior Authorizations. Each utilization review organization must report to the commissioner of commerce. The reports must include but are not limited to the total number of prior authorization requests, the number of requests for which an authorization was issued, and the number of prior authorization requests that an adverse determination was issued.

Section 12 (section 147.091, subdivision 1b). The board may investigate allegations and impose disciplinary action against a physician for failure to apply current evidence when making a utilization review determination, or failure to exercise a certain degree of care.

Section 13 Commissioner of Commerce; Analysis and Report to the Legislature. The commissioner must issue a report to the legislature by December 15, 2026, containing the commissioner's analysis and recommendations based on the data submitted by the utilization review organizations.

Section 14 Initial Reports to Commissioner of Commerce; Utilization Management Tools. Utilization review organizations must submit initial reports to the commissioner by September 1, 2025.