Senator Klein from the Committee on Commerce and Consumer Protection, to which was referred

S.F. No. 3532: A bill for an act relating to health care; modifying requirements for prior authorization and coverage of health care services; modifying a ground for disciplinary action against physicians; requiring reports to the commissioner of commerce and a report to the legislature; classifying data; authorizing rulemaking; amending Minnesota Statutes 2022, sections 62M.01, subdivision 3; 62M.02, subdivision 1a; 62M.05, subdivision 3a, by adding a subdivision; 62M.07, subdivision 2, by adding a subdivision; 62M.17, subdivision 2; 147.091, subdivision 1b; proposing coding for new law in Minnesota Statutes, chapters 62A; 62M; repealing Minnesota Statutes 2022, section 62D.12, subdivision 19.

Reports the same back with the recommendation that the bill be amended as follows:

Page 1, after line 20, insert:

"**EFFECTIVE DATE.** This section is effective January 1, 2026, and applies to health plans offered, sold, issued, or renewed on or after that date."

Page 1, delete section 2 and insert:

"Sec. 2. Minnesota Statutes 2022, section 62D.12, subdivision 19, is amended to read:

Subd. 19. **Coverage of service.** A health maintenance organization may not deny or limit coverage of a service which the enrollee has already received solely on the basis of lack of prior authorization or second opinion, to the extent that the service would otherwise have been covered under the member's contract by the health maintenance organization had prior authorization or second opinion been obtained. This subdivision expires December 31, 2025, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 3. Minnesota Statutes 2022, section 62M.01, subdivision 3, is amended to read:

Subd. 3. **Scope.** (a) Nothing in this chapter applies to review of claims after submission to determine eligibility for benefits under a health benefit plan. The appeal procedure described in section 62M.06 applies to any complaint as defined under section 62Q.68, subdivision 2, that requires a medical determination in its resolution.

(b) This chapter does not apply to managed care plans or county-based purchasing plans when the plan is providing coverage to state public health care program enrollees under chapter 256B or 256L. This paragraph expires December 31, 2025, for health plans offered, sold, issued, or renewed on or after that date.

(c) Effective January 1, 2026, and applicable to health plans offered, sold, issued, or renewed on or after that date, this chapter applies to services delivered through fee-for-service under chapter 256B, and to managed care plans and county-based purchasing plans when

the plan is providing coverage to state public health care program enrollees under chapter 256B or 256L."

Page 2, after line 12, insert:

"**EFFECTIVE DATE.** This section is effective the day following final enactment."

Page 3, after line 25, insert:

"**EFFECTIVE DATE.** This section is effective the day following final enactment."

Page 3, line 28, before "A utilization" insert "This subdivision is effective January 1, 2026, and applies to health plans offered, sold, issued, or renewed on or after that date."

Page 4, line 23, delete "or" and insert a comma

Page 4, line 24, after "Book" insert ", or a biosimilar"

Page 5, line 2, after the semicolon, insert "and"

Page 5, line 4, delete "; and" and insert a period

Page 5, delete lines 5 to 10 and insert:

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

Page 5, line 13, before "An authorization" insert "This subdivision is effective January 1, 2026, and applies to health plans offered, sold, issued, or renewed on or after that date." and after the second "a" insert "chronic"

Page 5, line 14, delete "that an enrollee is expected to have for longer than one year"

Page 5, line 15, after the period, insert "A chronic health condition is a condition that is expected to last one year or more and:"

Page 5, after line 15, insert:

"(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."

Page 5, delete section 8 and insert:

"Sec. 9. Minnesota Statutes 2022, section 62M.07, is amended by adding a subdivision to read:

Subd. 6. **Value-based contracts.** This subdivision is effective January 1, 2026, and applies to health plans offered, sold, issued, or renewed on or after that date. No utilization review organization, health plan company, or claims administrator may conduct or require prior authorization for services that are reimbursed through a value-based contract that:

(1) ties payment for the provision of health care services to the quality of health care provided;

(2) rewards a provider for efficiency and effectiveness; and

(3) imposes a risk-sharing requirement on the provider for health care services that do not meet the health plan company's requirements for quality, effectiveness, and efficiency."

Page 6, delete section 9 and insert:

"Sec. 10. Minnesota Statutes 2022, section 62M.17, subdivision 2, is amended to read:

Subd. 2. **Effect of change in prior authorization clinical criteria.** (a) If, during a plan year, a utilization review organization changes coverage terms for a health care service or the clinical criteria used to conduct prior authorizations for a health care service, the change in coverage terms or change in clinical criteria shall not apply until the next plan year for any enrollee who received prior authorization for a health care service using the coverage terms or clinical criteria in effect before the effective date of the change.

(b) Paragraph (a) does not apply if a utilization review organization changes coverage terms for a drug or device that has been deemed unsafe by the United States Food and Drug Administration (FDA); that has been withdrawn by either the FDA or the product manufacturer; or when an independent source of research, clinical guidelines, or evidence-based standards has issued drug- or device-specific warnings or recommended changes in drug or device usage.

(c) Paragraph (a) does not apply if a utilization review organization changes coverage terms for a service or the clinical criteria used to conduct prior authorizations for a service when an independent source of research, clinical guidelines, or evidence-based standards has recommended changes in usage of the service for reasons related to patient harm. This paragraph expires December 31, 2025, for health plans offered, sold, issued, or renewed on or after that date.

(d) Effective January 1, 2026, and applicable to health plans offered, sold, issued, or renewed on or after that date, paragraph (a) does not apply if a utilization review organization changes coverage terms for a service or the clinical criteria used to conduct prior authorizations for a service when an independent source of research, clinical guidelines, or evidence-based standards has recommended changes in usage of the service for reasons related to previously unknown and imminent patient harm.

~~(d)~~ (e) Paragraph (a) does not apply if a utilization review organization removes a brand name drug from its formulary or places a brand name drug in a benefit category that increases the enrollee's cost, provided the utilization review organization (1) adds to its formulary a generic or multisource brand name drug rated as therapeutically equivalent according to the FDA Orange Book, or a biologic drug rated as interchangeable according to the FDA Purple Book, at a lower cost to the enrollee, and (2) provides at least a 60-day notice to prescribers, pharmacists, and affected enrollees."

Page 9, after line 7, insert:

"**EFFECTIVE DATE.** This section is effective the day following final enactment."

Page 9, line 18, after the second "care" insert ", including recommendations for a prior authorization exemption process for providers and group practices that have an authorization rate for all submitted requests for authorization at or above a level determined by the commissioner as qualifying for the exemption"

Page 9, line 22, delete "January" and insert "December"

Page 9, delete section 14

Renumber the sections in sequence

Amend the title as follows:

Page 1, line 5, delete "authorizing rulemaking;"

Amend the title numbers accordingly

And when so amended the bill do pass and be re-referred to the Committee on Health and Human Services. Amendments adopted. Report adopted.

.....
(Committee Chair)

March 5, 2024.....
(Date of Committee recommendation)