Senator ..... moves to amend the delete-everything amendment (SCS4699A-2) to S.F. No. 4699 as follows:

Page 65, after line 21, insert:

"Sec. 5. **[62A.59] COVERAGE OF SERVICE; PRIOR AUTHORIZATION.**

Subdivision 1. **Service for which prior authorization not required.** A health carrier must not retrospectively deny or limit coverage of a health care service for which prior authorization was not required by the health carrier, unless there is evidence that the health care service was provided based on fraud or misinformation.

Subd. 2. **Service for which prior authorization required but not obtained.** A health carrier 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, 2026, and applies to health plans offered, sold, issued, or renewed on or after that date."

Page 68, after line 17, insert:

"Sec. 13. 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."

Page 69, after line 29, insert:

"Sec. 18. 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.

Sec. 19. Minnesota Statutes 2022, section 62M.02, subdivision 1a, is amended to read:

Subd. 1a. **Adverse determination.** "Adverse determination" means a decision by a utilization review organization relating to an admission, extension of stay, or health care service that is partially or wholly adverse to the enrollee, including: (1) a decision to deny an admission, extension of stay, or health care service on the basis that it is not medically necessary; or (2) an authorization for a health care service that is less intensive than the health care service specified in the original request for authorization.

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

Sec. 20. Minnesota Statutes 2022, section 62M.05, subdivision 3a, is amended to read:

Subd. 3a. **Standard review determination.** (a) ~~Notwithstanding subdivision 3b, a standard review determination on all requests for utilization review must be communicated to the provider and enrollee in accordance with this subdivision within five business days after receiving the request if the request is received electronically, or within six business days if received through nonelectronic means, provided that all information reasonably necessary to make a determination on the request has been made available to the utilization review organization. Effective January 1, 2022,~~ A standard review determination on all requests for utilization review must be communicated to the provider and enrollee in accordance with this subdivision within five business days after receiving the request, regardless of how the request was received, provided that all information reasonably necessary to make a determination on the request has been made available to the utilization review organization.

(b) When a determination is made to authorize, notification must be provided promptly by telephone to the provider. The utilization review organization shall send written notification to the provider or shall maintain an audit trail of the determination and telephone notification. For purposes of this subdivision, "audit trail" includes documentation of the telephone notification, including the date; the name of the person spoken to; the enrollee;

the service, procedure, or admission authorized; and the date of the service, procedure, or admission. If the utilization review organization indicates authorization by use of a number, the number must be called the "authorization number." For purposes of this subdivision, notification may also be made by facsimile to a verified number or by electronic mail to a secure electronic mailbox. These electronic forms of notification satisfy the "audit trail" requirement of this paragraph.

(c) When an adverse determination is made, notification must be provided within the time periods specified in paragraph (a) by telephone, by facsimile to a verified number, or by electronic mail to a secure electronic mailbox to the attending health care professional and hospital or physician office as applicable. Written notification must also be sent to the hospital or physician office as applicable and attending health care professional if notification occurred by telephone. For purposes of this subdivision, notification may be made by facsimile to a verified number or by electronic mail to a secure electronic mailbox. Written notification must be sent to the enrollee and may be sent by United States mail, facsimile to a verified number, or by electronic mail to a secure mailbox. The written notification must include all reasons relied on by the utilization review organization for the determination and the process for initiating an appeal of the determination. Upon request, the utilization review organization shall provide the provider or enrollee with the criteria used to determine the necessity, appropriateness, and efficacy of the health care service and identify the database, professional treatment parameter, or other basis for the criteria. Reasons for an adverse determination may include, among other things, the lack of adequate information to authorize after a reasonable attempt has been made to contact the provider or enrollee.

(d) When an adverse determination is made, the written notification must inform the enrollee and the attending health care professional of the right to submit an appeal to the internal appeal process described in section 62M.06 and the procedure for initiating the internal appeal. The written notice shall be provided in a culturally and linguistically appropriate manner consistent with the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a.

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

Sec. 21. Minnesota Statutes 2022, section 62M.07, subdivision 2, is amended to read:

Subd. 2. **Prior authorization of ~~emergency~~ 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) medication to treat a substance use disorder;

(3) a generic drug or multisource brand name drug rated as therapeutically equivalent according to the FDA Orange Book, a biologic drug rated as interchangeable according to the FDA Purple Book, or a biosimilar;

(4) outpatient mental health treatment or outpatient substance use disorder treatment;

(5) antineoplastic cancer treatment that is consistent with guidelines of the National Comprehensive Cancer Network;

(6) 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;

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

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

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

Sec. 22. Minnesota Statutes 2022, section 62M.07, subdivision 4, is amended to read:

Subd. 4. **Submission of prior authorization requests.** (a) If prior authorization for a health care service is required, the utilization review organization, health plan company, or claim administrator must allow providers to submit requests for prior authorization of the health care services without unreasonable delay by telephone, facsimile, or voice mail or through an electronic mechanism 24 hours a day, seven days a week. This subdivision does not apply to dental service covered under MinnesotaCare or medical assistance.

(b) Effective January 1, 2027, for health plans offered, sold, issued, or renewed on or after that date, utilization review organizations, health plan companies, and claims administrators must have and maintain a prior authorization application programming

interface (API) that automates the prior authorization process for health care services, excluding prescription drugs and medications. The API must allow providers to determine whether a prior authorization is required for health care services, identify prior authorization information and documentation requirements, and facilitate the exchange of prior authorization requests and determinations from provider electronic health records or practice management systems. The API must use the Health Level Seven (HL7) Fast Healthcare Interoperability Resources (FHIR) standard in accordance with United States Code, title 45, section 170.215(a)(1), and the most recent standards and guidance adopted by the United States Department of Health and Human Services to implement that section. Prior authorization submission requests for prescription drugs and medications must comply with requirements of section 62J.497.

Sec. 23. Minnesota Statutes 2022, section 62M.07, is amended by adding a subdivision to read:

Subd. 5. **Treatment of a chronic condition.** This subdivision is effective January 1, 2026, and applies to health plans offered, sold, issued, or renewed on or after that date. An authorization for treatment of a chronic health condition does not expire unless the standard of treatment for that health condition changes. 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.

Sec. 24. 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.

Sec. 25. 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.

Sec. 26. **[62M.19] ANNUAL REPORT TO COMMISSIONER OF HEALTH; PRIOR AUTHORIZATIONS.**

Subdivision 1. **Annual report; contents.** On or before September 1 each year, each utilization review organization must report to the commissioner of health, in a form and manner specified by the commissioner, information on prior authorization requests for the previous calendar year. The report submitted under this subdivision must include the following data, sorted by the categories of services listed in subdivision 2:

(1) the total number of prior authorization requests received;

(2) the number of prior authorization requests for which an authorization was issued;

(3) the number of prior authorization requests for which an adverse determination was issued;

(4) the number of adverse determinations reversed on appeal;

(5) the 25 codes with the highest number of prior authorization requests and the percentage of authorizations for each of these codes;

(6) the 25 codes with the highest percentage of prior authorization requests for which an authorization was issued and the total number of the requests;

(7) the 25 codes with the highest percentage of prior authorization requests for which an adverse determination was issued but which was reversed on appeal and the total number of the requests;

(8) the 25 codes with the highest percentage of prior authorization requests for which an adverse determination was issued and the total number of the requests; and

(9) the reasons an adverse determination to a prior authorization request was issued, expressed as a percentage of all adverse determinations for each category of services listed in subdivision 2. The reasons listed may include but are not limited to:

(i) the patient did not meet prior authorization criteria;

(ii) incomplete information was submitted by the provider to the utilization review organization;

(iii) the treatment program changed; and

(iv) the patient is no longer covered by the health benefit plan.

Subd. 2. **Categories of services.** The data submitted to the commissioner under subdivision 1 must be sorted by the following categories of services:

(1) inpatient medical and surgical services;

(2) outpatient medical and surgical services;

(3) inpatient mental health and substance use disorder services;

(4) outpatient mental health and substance use disorder services;

(5) diagnostic imaging services;

(6) diabetes supplies and equipment;

(7) durable medical equipment; and

(8) prescription drugs."

Page 86, after line 18, insert:

"Sec. 48. **COMMISSIONER OF HEALTH; ANALYSIS AND REPORT TO THE LEGISLATURE.**

(a) The commissioner of health must use the data submitted by utilization review organizations under Minnesota Statutes, section 62M.19, and may use other data available to the commissioner to analyze the use of prior authorization in health care. The analysis must evaluate the effect prior authorization has on patient access to care, the administrative burden the use of utilization management tools places on health care providers, and system costs. The commissioner must also develop recommendations on how to simplify health insurance prior authorization standards and processes to improve health care access, reduce delays in care, reduce the administrative burden on health care providers, and maximize quality of care, 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. When conducting the analysis and developing recommendations, the commissioner must consult with physicians, other providers, health plan companies, consumers, or other health care experts, as appropriate.

(b) The commissioner must issue a report to the legislature by December 15, 2026, containing the commissioner's analysis and recommendations under paragraph (a).

Sec. 49. **INITIAL REPORTS TO COMMISSIONER OF HEALTH; UTILIZATION MANAGEMENT TOOLS.**

Utilization review organizations must submit initial reports to the commissioner of health under Minnesota Statutes, section 62M.19, by September 1, 2025."

Renumber the sections in sequence and correct the internal references