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State of Minnesota
HOUSE OF REPRESENTATIVES

**EIGHTY-FIFTH
SESSION**

HOUSE FILE No. 3817

March 4, 2008

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The bill was read for the first time and referred to the Committee on Health and Human Services

1.1 A bill for an act
1.2 relating to insurance; requiring health insurers to honor the patient's assignment
1.3 of benefits; amending Minnesota Statutes 2006, section 72A.201, subdivision 4.

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

1.5 Section 1. Minnesota Statutes 2006, section 72A.201, subdivision 4, is amended to
1.6 read:

1.7 Subd. 4. **Standards for claim filing and handling.** The following acts by an
1.8 insurer, an adjuster, a self-insured, or a self-insurance administrator constitute unfair
1.9 settlement practices:

1.10 (1) except for claims made under a health insurance policy, after receiving
1.11 notification of claim from an insured or a claimant, failing to acknowledge receipt of the
1.12 notification of the claim within ten business days, and failing to promptly provide all
1.13 necessary claim forms and instructions to process the claim, unless the claim is settled
1.14 within ten business days. The acknowledgment must include the telephone number of the
1.15 company representative who can assist the insured or the claimant in providing information
1.16 and assistance that is reasonable so that the insured or claimant can comply with the policy
1.17 conditions and the insurer's reasonable requirements. If an acknowledgment is made by
1.18 means other than writing, an appropriate notation of the acknowledgment must be made in
1.19 the claim file of the insurer and dated. An appropriate notation must include at least the
1.20 following information where the acknowledgment is by telephone or oral contact:

- 1.21 (i) the telephone number called, if any;
- 1.22 (ii) the name of the person making the telephone call or oral contact;
- 1.23 (iii) the name of the person who actually received the telephone call or oral contact;
- 1.24 (iv) the time of the telephone call or oral contact; and

- 2.1 (v) the date of the telephone call or oral contact;
- 2.2 (2) failing to reply, within ten business days of receipt, to all other communications
- 2.3 about a claim from an insured or a claimant that reasonably indicate a response is
- 2.4 requested or needed;
- 2.5 (3)(i) unless provided otherwise by clause (ii) or (iii), other law, or in the policy,
- 2.6 failing to complete its investigation and inform the insured or claimant of acceptance or
- 2.7 denial of a claim within 30 business days after receipt of notification of claim unless
- 2.8 the investigation cannot be reasonably completed within that time. In the event that the
- 2.9 investigation cannot reasonably be completed within that time, the insurer shall notify
- 2.10 the insured or claimant within the time period of the reasons why the investigation is not
- 2.11 complete and the expected date the investigation will be complete. For claims made under
- 2.12 a health policy the notification of claim must be in writing;
- 2.13 (ii) for claims submitted under a health policy, the insurer must comply with all of
- 2.14 the requirements of section 62Q.75;
- 2.15 (iii) for claims submitted under a health policy that are accepted, the insurer must
- 2.16 notify the insured or claimant no less than semiannually of the disposition of claims of the
- 2.17 insured or claimant. For purposes of this clause, acceptance of a claim means that there
- 2.18 is no additional financial liability for the insured or claimant, either because there is a
- 2.19 flat co-payment amount specified in the health plan or because there is no co-payment,
- 2.20 deductible, or coinsurance owed;
- 2.21 (4) where evidence of suspected fraud is present, the requirement to disclose their
- 2.22 reasons for failure to complete the investigation within the time period set forth in clause
- 2.23 (3) need not be specific. The insurer must make this evidence available to the Department
- 2.24 of Commerce if requested;
- 2.25 (5) failing to notify an insured who has made a notification of claim of all available
- 2.26 benefits or coverages which the insured may be eligible to receive under the terms of a
- 2.27 policy and of the documentation which the insured must supply in order to ascertain
- 2.28 eligibility;
- 2.29 (6) unless otherwise provided by law or in the policy, requiring an insured to give
- 2.30 written notice of loss or proof of loss within a specified time, and thereafter seeking to
- 2.31 relieve the insurer of its obligations if the time limit is not complied with, unless the
- 2.32 failure to comply with the time limit prejudices the insurer's rights and then only if the
- 2.33 insurer gave prior notice to the insured of the potential prejudice;
- 2.34 (7) advising an insured or a claimant not to obtain the services of an attorney or
- 2.35 an adjuster, or representing that payment will be delayed if an attorney or an adjuster
- 2.36 is retained by the insured or the claimant;

3.1 (8) failing to advise in writing an insured or claimant who has filed a notification of
3.2 claim known to be unresolved, and who has not retained an attorney, of the expiration of
3.3 a statute of limitations at least 60 days prior to that expiration. For the purposes of this
3.4 clause, any claim on which the insurer has received no communication from the insured
3.5 or claimant for a period of two years preceding the expiration of the applicable statute
3.6 of limitations shall not be considered to be known to be unresolved and notice need not
3.7 be sent pursuant to this clause;

3.8 (9) demanding information which would not affect the settlement of the claim;

3.9 (10) unless expressly permitted by law or the policy, refusing to settle a claim of an
3.10 insured on the basis that the responsibility should be assumed by others;

3.11 (11) failing, within 60 business days after receipt of a properly executed proof of loss,
3.12 to advise the insured of the acceptance or denial of the claim by the insurer. No insurer
3.13 shall deny a claim on the grounds of a specific policy provision, condition, or exclusion
3.14 unless reference to the provision, condition, or exclusion is included in the denial. The
3.15 denial must be given to the insured in writing with a copy filed in the claim file;

3.16 (12) denying or reducing a claim on the basis of an application which was altered or
3.17 falsified by the agent or insurer without the knowledge of the insured;

3.18 (13) failing to notify the insured of the existence of the additional living expense
3.19 coverage when an insured under a homeowners policy sustains a loss by reason of a
3.20 covered occurrence and the damage to the dwelling is such that it is not habitable;

3.21 (14) failing to inform an insured or a claimant that the insurer will pay for an
3.22 estimate of repair if the insurer requested the estimate and the insured or claimant had
3.23 previously submitted two estimates of repair;

3.24 (15) in connection with a claim under a health plan or other health insurance
3.25 coverage, failing to honor a patient's assignment of benefits requiring the insurer to make
3.26 the payment on the claim directly to the health care provider if:

3.27 (i) the provider is in the network of providers covered under the patient's health plan
3.28 or other health insurance coverage under which the claim was submitted; and

3.29 (ii) the insurer received the assignment of benefits no later than two days before
3.30 making payment on the claim.

3.31 Clause (15) applies regardless of whether the assignment of benefits form signed by
3.32 the patient made payment directly to the provider optional on the part of the insurer.

3.33 **EFFECTIVE DATE.** This section is effective August 1, 2008, and applies to claims
3.34 submitted on or after that date.