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State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-SIXTH SESSION

HOUSE FILE NO. 1345

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

1.1 A bill for an act
1.2 relating to insurance; prohibiting certain claims processing practices by
1.3 third-party administrators of health coverage plans; regulating health claims
1.4 clearinghouses; providing a time limit on insurer audits of health claims
1.5 payments; amending Minnesota Statutes 2008, section 60A.23, subdivision 8;
1.6 proposing coding for new law in Minnesota Statutes, chapter 62Q.

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

1.8 Section 1. Minnesota Statutes 2008, section 60A.23, subdivision 8, is amended to read:

1.9 Subd. 8. **Self-insurance or insurance plan administrators who are vendors**
1.10 **of risk management services.** (1) **Scope.** This subdivision applies to any vendor of
1.11 risk management services and to any entity which administers, for compensation, a
1.12 self-insurance or insurance plan. This subdivision does not apply (a) to an insurance
1.13 company authorized to transact insurance in this state, as defined by section 60A.06,
1.14 subdivision 1, clauses (4) and (5); (b) to a service plan corporation, as defined by section
1.15 62C.02, subdivision 6; (c) to a health maintenance organization, as defined by section
1.16 62D.02, subdivision 4; (d) to an employer directly operating a self-insurance plan for
1.17 its employees' benefits; (e) to an entity which administers a program of health benefits
1.18 established pursuant to a collective bargaining agreement between an employer, or group
1.19 or association of employers, and a union or unions; or (f) to an entity which administers a
1.20 self-insurance or insurance plan if a licensed Minnesota insurer is providing insurance
1.21 to the plan and if the licensed insurer has appointed the entity administering the plan as
1.22 one of its licensed agents within this state.

1.23 (2) **Definitions.** For purposes of this subdivision the following terms have the
1.24 meanings given them.

2.1 (a) "Administering a self-insurance or insurance plan" means (i) processing,
2.2 reviewing or paying claims, (ii) establishing or operating funds and accounts, or (iii)
2.3 otherwise providing necessary administrative services in connection with the operation of
2.4 a self-insurance or insurance plan.

2.5 (b) "Employer" means an employer, as defined by section 62E.02, subdivision 2.

2.6 (c) "Entity" means any association, corporation, partnership, sole proprietorship,
2.7 trust, or other business entity engaged in or transacting business in this state.

2.8 (d) "Self-insurance or insurance plan" means a plan providing life, medical or
2.9 hospital care, accident, sickness or disability insurance for the benefit of employees or
2.10 members of an association, or a plan providing liability coverage for any other risk or
2.11 hazard, which is or is not directly insured or provided by a licensed insurer, service plan
2.12 corporation, or health maintenance organization.

2.13 (e) "Vendor of risk management services" means an entity providing for
2.14 compensation actuarial, financial management, accounting, legal or other services for the
2.15 purpose of designing and establishing a self-insurance or insurance plan for an employer.

2.16 (3) **License.** No vendor of risk management services or entity administering a
2.17 self-insurance or insurance plan may transact this business in this state unless it is licensed
2.18 to do so by the commissioner. An applicant for a license shall state in writing the type of
2.19 activities it seeks authorization to engage in and the type of services it seeks authorization
2.20 to provide. The license may be granted only when the commissioner is satisfied that the
2.21 entity possesses the necessary organization, background, expertise, and financial integrity
2.22 to supply the services sought to be offered. The commissioner may issue a license subject
2.23 to restrictions or limitations upon the authorization, including the type of services which
2.24 may be supplied or the activities which may be engaged in. The license fee is $1,500
2.25 for the initial application and $1,500 for each three-year renewal. All licenses are for
2.26 a period of three years.

2.27 (4) **Regulatory restrictions; powers of the commissioner.** To assure that
2.28 self-insurance or insurance plans are financially solvent, are administered in a fair and
2.29 equitable fashion, and are processing claims and paying benefits in a prompt, fair,
2.30 and honest manner, vendors of risk management services and entities administering
2.31 insurance or self-insurance plans are subject to the supervision and examination by the
2.32 commissioner. Vendors of risk management services, entities administering insurance or
2.33 self-insurance plans, and insurance or self-insurance plans established or operated by
2.34 them are subject to the trade practice requirements of sections 72A.19 to 72A.30. In lieu
2.35 of an unlimited guarantee from a parent corporation for a vendor of risk management
2.36 services or an entity administering insurance or self-insurance plans, the commissioner

3.1 may accept a surety bond in a form satisfactory to the commissioner in an amount equal to
3.2 120 percent of the total amount of claims handled by the applicant in the prior year. If at
3.3 any time the total amount of claims handled during a year exceeds the amount upon which
3.4 the bond was calculated, the administrator shall immediately notify the commissioner.
3.5 The commissioner may require that the bond be increased accordingly.

3.6 No contract entered into after July 1, 2001, between a licensed vendor of risk
3.7 management services and a group authorized to self-insure for workers' compensation
3.8 liabilities under section 79A.03, subdivision 6, may take effect until it has been filed
3.9 with the commissioner, and either (1) the commissioner has approved it or (2) 60 days
3.10 have elapsed and the commissioner has not disapproved it as misleading or violative of
3.11 public policy.

3.12 (5) **Rulemaking authority.** To carry out the purposes of this subdivision, the
3.13 commissioner may adopt rules pursuant to sections 14.001 to 14.69. These rules may:

3.14 (a) establish reporting requirements for administrators of insurance or self-insurance
3.15 plans;

3.16 (b) establish standards and guidelines to assure the adequacy of financing, reinsuring,
3.17 and administration of insurance or self-insurance plans;

3.18 (c) establish bonding requirements or other provisions assuring the financial integrity
3.19 of entities administering insurance or self-insurance plans; or

3.20 (d) establish other reasonable requirements to further the purposes of this
3.21 subdivision.

3.22 (6) **Claims processing practices.** No entity administering a self-insurance or
3.23 insurance plan shall:

3.24 (a) require a patient to pay for care provided by an in-network provider an amount
3.25 that exceeds the fee negotiated between the entity and that provider for the type of care
3.26 provided;

3.27 (b) attempt to recoup from the provider a payment owed to the provider by the
3.28 patient for deductibles, co-pays, coinsurance, or other enrollee cost-sharing required under
3.29 the plan, unless the administrator has confirmed with the provider that the patient has
3.30 paid the cost-sharing amounts in full; or

3.31 (c) limit the time period within which a provider may submit claims to the entity to a
3.32 period less than the period described in section 62Q.75, subdivision 3.

3.33 **EFFECTIVE DATE.** This section is effective August 1, 2009, and applies to
3.34 patient care provided on or after that date.

3.35 Sec. 2. **[62Q.7375] HEALTH CARE CLEARINGHOUSES.**

4.1 Subdivision 1. **Definition.** For the purposes of this section, "health care
4.2 clearinghouse" or "clearinghouse" means a public or private entity, including a billing
4.3 service, repricing company, community health management information system or
4.4 community health information system, and "value-added" networks and switches, that
4.5 does either of the following functions:

4.6 (1) processes or facilitates the processing of health information received from
4.7 another entity in a nonstandard format or containing nonstandard data content into
4.8 standard data elements or a standard transaction; or

4.9 (2) receives a standard transaction from another entity and processes or facilitates
4.10 the processing of health information into nonstandard format or nonstandard data content
4.11 for the receiving entity.

4.12 Subd. 2. **Claims submission deadlines and careful handling.** (a) A health care
4.13 clearinghouse must not have or enforce a deadline for submission of claims that is shorter
4.14 than the period provided in section 62Q.75, subdivision 3.

4.15 (b) A claim submitted to a health care clearinghouse within the time permitted
4.16 under paragraph (a) must be treated as timely by the clearinghouse and by any entity that
4.17 contracts with the clearinghouse. This paragraph does apply if the provider submitted the
4.18 claim to a clearinghouse that does not have the ability or authority to transmit the claim to
4.19 the relevant health plan company.

4.20 (c) If a clearinghouse destroys or loses a claim or transmits it to the wrong entity for
4.21 processing, resulting in the provider not getting paid or reimbursed, the clearinghouse is
4.22 liable to the provider or other person who incurred the loss and shall promptly pay to the
4.23 provider or other person the amount claimed, plus interest at six percent per annum.

4.24 **EFFECTIVE DATE.** This section is effective August 1, 2009, and applies to claims
4.25 transmitted to a clearinghouse on or after that date.

4.26 Sec. 3. **[62Q.748] HEALTH CLAIMS PAYMENT AUDITS; TIME LIMIT.**

4.27 (a) No health plan company providing health coverage in this state and no insurance
4.28 company providing motor vehicle or workers' compensation coverage in this state shall
4.29 audit, review, or seek to recover a paid health care claim at a time that is more than three
4.30 months after the claim was paid.

4.31 (b) No health plan company providing health coverage in this state and no insurance
4.32 company providing motor vehicle or workers' compensation coverage in this state shall
4.33 withhold payment on current claims during the pendency of an audit unless the audit
4.34 dispute has reached final adjudication.

5.1 (c) This section does not apply to an investigation based on a reasonable belief of
5.2 suspected insurance fraud under sections 60A.951 to 60A.956 by an authorized person as
5.3 defined in section 60A.951, subdivision 2.

5.4 **EFFECTIVE DATE.** This section is effective August 1, 2009, and applies to claims
5.5 paid before, on, or after that date.