State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-EIGHTH SESSION

H. F. No. 3073

03/13/2014 Authored by Atkins
The bill was read for the first time and referred to the Committee on Commerce and Consumer Protection Finance and Policy
03/20/2014 Adoption of Report: Amended and re-referred to the Committee on Judiciary Finance and Policy

A bill for an act

relating to insurance; modifying certain regulations to reduce the incidence of insurance fraud; providing an administrative penalty for insurance fraud; regulating no-fault auto benefits; regulating certain property and casualty coverages; creating a process for deauthorization of the right of health care providers to receive certain payments under chapter 65B; limiting reimbursement for certain prescription drugs; regulating batch billing; modifying certain economic benefits under chapter 65B; establishing a task force on motor vehicle insurance coverage verification; amending Minnesota Statutes 2012, sections 13.7191, subdivision 16; 60A.952, subdivision 3; 65B.44, subdivisions 2, 3, 4, 6, by adding a subdivision; 65B.525, by adding a subdivision; 65B.54, subdivision 2; 72A.502, subdivision 2; Minnesota Statutes 2013 Supplement, section 45.0135, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapters 45; 60A; repealing Minnesota Statutes 2012, section 72A.327.

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

Section 1. Minnesota Statutes 2012, section 13.7191, subdivision 16, is amended to read:

Subd. 16. **Regulation of trade practices; insurance contract data.** ~~(a) **Insurance contract data.**~~ Certain insurance contract data held by the commissioner of commerce are classified under section 72A.20, subdivision 15.

~~(b) **Health claims appeals.** Documents that are part of an appeal from denial of health care coverage for experimental treatment are classified under section 72A.327.~~

Sec. 2. Minnesota Statutes 2013 Supplement, section 45.0135, is amended by adding a subdivision to read:

Subd. 9. **Administrative penalty for insurance fraud.** (a) In addition to any criminal penalties that may be imposed under section 609.611, on a showing by a preponderance of the evidence that a violation of section 609.611 has occurred, the commissioner may:

(1) impose an administrative penalty not exceeding $25,000 for each act of insurance fraud; and

(2) order restitution to an insurer or self-insured employer of any insurance proceeds paid relating to a fraudulent insurance claim.

(b) In determining the amount of the administrative penalty, the commissioner must consider:

(1) the nature, circumstances, extent, gravity, and number of violations;

(2) the degree of culpability of the violator;

(3) prior offenses and repeated violations of the violator; and

(4) any other matter that the commissioner considers appropriate and relevant.

(c) If an administrative penalty is not paid after all rights of appeal have been waived or exhausted, the commissioner may bring a civil action in a court of competent jurisdiction to collect the administrative penalty, including expenses and litigation costs, reasonable attorney fees, and interest.

(d) This section does not affect an insurer's right to take any independent action to seek recovery against a person that violates this section.

Sec. 3. **[45.0137] DEAUTHORIZATION OF PROVIDERS FROM RECEIVING CERTAIN PAYMENTS UNDER CHAPTER 65B.**

Subdivision 1. **Definitions.** (a) As used in this section, the following terms have the meaning given.

(b) "Appropriate licensing authority" means the state agency responsible for licensing and discipline of a provider.

(c) "Commissioner" means the commissioner of commerce.

(d) "Medical services" means those services eligible for reimbursement under section 65B.44, subdivision 2.

(e) "Provider of medical services" or "provider" means a person or entity that has provided medical services.

Subd. 2. **Deauthorization of providers.** The commissioner, or an appropriate licensing authority, may, by order, remove authorization for a provider of medical services to demand or request payment for medical services upon finding, after investigation as provided in subdivision 3, that the provider:

(1) has been guilty of professional or other misconduct or incompetency in connection with medical services rendered;

(2) has exceeded the limits of professional competence in providing medical services or has knowingly made a false statement or representation as to a material fact in any report made in connection with any claim under chapter 65B;

(3) solicited, or has employed another to solicit for the provider or for another, professional treatment, examination, or care of an injured person in connection with any claim under chapter 65B;

(4) has refused to appear before, or to answer upon request of, the commissioner or duly authorized officer of an appropriate licensing authority, any legal question, or to produce any relevant information concerning conduct in connection with providing medical services; or

(5) has engaged in patterns of billing for medical services that were not provided.

Subd. 3. **Investigation.** (a) The commissioner may investigate any reports made under section 45.0135, or other information in the commissioner's possession, regarding providers of medical services engaging in any of the unlawful activities set forth in subdivision 2. After conducting an investigation, the commissioner must send to the appropriate licensing authority a list of any providers who the commissioner believes may have engaged in any of the unlawful activities set forth in subdivision 2 together with a description of the grounds for inclusion on the list. Within 45 days of receipt of the list, the appropriate licensing authority shall notify the commissioner in writing whether the licensing authority confirms that the commissioner has a reasonable basis to proceed with notice and a hearing for determining whether any of the listed providers should be deauthorized from demanding or requesting any payment for medical services.

(b) An appropriate licensing authority may also investigate any reports, allegations, or other information in its possession regarding providers engaging in any of the unlawful activities set forth in subdivision 2. If the appropriate licensing authority conducts an investigation, then that authority is responsible for providing notice and an opportunity to be heard to the providers that are subject to deauthorization from demanding or requesting any payment for medical services.

(c) Hearings under this section must be conducted in accordance with chapter 14 and any other applicable law.

Sec. 4. **[60A.0812] PROHIBITED EXCLUSION; CERTAIN PROPERTY AND CASUALTY POLICIES.**

An automobile insurance policy, personal excess liability policy, or personal umbrella policy must not contain an exclusion of, or limitation on, liability for damages

for bodily injury solely because the injured person is a resident or member of the insured's household, or is related to the insured by blood or marriage.

EFFECTIVE DATE. This section is effective January 1, 2015, and applies to policies issued, renewed, or continued on or after that date.

Sec. 5. Minnesota Statutes 2012, section 60A.952, subdivision 3, is amended to read:

Subd. 3. **Immunity from liability.** If insurers, insurance support organizations as defined in section 72A.491, subdivision 12, agents acting on the insurers' behalf, or authorized persons release information in good faith under this section, whether orally or in writing, they are immune from any liability, civil or criminal, for the release or reporting of the information.

Sec. 6. Minnesota Statutes 2012, section 65B.44, subdivision 2, is amended to read:

Subd. 2. **Medical expense benefits.** (a) Medical expense benefits shall reimburse all reasonable expenses for necessary:

(1) medical, surgical, x-ray, optical, dental, chiropractic, and rehabilitative services, including prosthetic devices;

(2) prescription drugs, provided that:

(i) prescription drugs filled and dispensed outside of a licensed pharmacy shall be billed at the average wholesale price (AWP), or its equivalent, for that drug on that date as published in Medispan or Redbook as identified by its National Drug Code, plus a dispensing fee of $4.18;

(ii) if a prescription drug has been repackaged, the average wholesale price used to determine the maximum reimbursement shall be the average wholesale price for the underlying drug product, as identified by its National Drug Code from the original labeler; and

(iii) compound drugs shall be billed by listing each drug and its National Drug Code number included in the compound and calculating the charge for each drug separately. Reimbursement shall be based on the sum of the fee for each ingredient for which there is an assigned National Drug Code number plus a single dispensing fee of $4.18. Compound drugs shall not be dispensed without first obtaining preauthorization from the reparation obligor;

(3) ambulance and all other transportation expenses incurred in traveling to receive other covered medical expense benefits;

(4) sign interpreting and language translation services, other than such services provided by a family member of the patient, related to the receipt of medical, surgical,

x-ray, optical, dental, chiropractic, hospital, extended care, nursing, and rehabilitative services; and

(5) hospital, extended care, and nursing services.

(b) Hospital room and board benefits may be limited, except for intensive care facilities, to the regular daily semiprivate room rates customarily charged by the institution in which the recipient of benefits is confined.

(c) Such benefits shall also include necessary remedial treatment and services recognized and permitted under the laws of this state for an injured person who relies upon spiritual means through prayer alone for healing in accordance with that person's religious beliefs.

(d) Medical expense loss includes medical expenses accrued prior to the death of a person notwithstanding the fact that benefits are paid or payable to the decedent's survivors.

(e) Medical expense benefits for rehabilitative services shall be subject to the provisions of section 65B.45.

Sec. 7. Minnesota Statutes 2012, section 65B.44, is amended by adding a subdivision to read:

Subd. 2a. **Billing.** (a) Providers of goods and services for which a medical expense benefit claim is submitted shall notify the appropriate reparation obligor of the date the services were commenced or the goods were first provided within 30 days of determining the identity of the reparation obligor, but in any event not later than 60 days from the date services were commenced or goods were first provided. Once the reparation obligor has been established, all bills must be submitted to the reparation obligor not later than 60 days from the date of service.

(b) If the provider of goods and services for which a medical expense benefit claim is submitted fails to submit a bill and supporting documentation to a reparation obligor as required in this subdivision, the medical expenses shall not be compensable.

Sec. 8. Minnesota Statutes 2012, section 65B.44, subdivision 3, is amended to read:

Subd. 3. **Disability and income loss benefits.** (a) Disability and income loss benefits shall provide compensation for 85 percent of the injured person's loss of present and future gross income from inability to work proximately caused by the nonfatal injury subject to a maximum of ~~$250~~ $500 per week. Loss of income includes the costs incurred by a self-employed person to hire substitute employees to perform tasks which are necessary to maintain the income of the injured person, which are normally performed by the injured person, and which cannot be performed because of the injury.

(b) If the injured person is unemployed at the time of injury and is receiving or is eligible to receive unemployment benefits under chapter 268, but the injured person loses eligibility for those benefits because of inability to work caused by the injury, disability and income loss benefits shall provide compensation for the lost benefits in an amount equal to the unemployment benefits which otherwise would have been payable, subject to a maximum of ~~$250~~ $500 per week.

(c) Compensation under this subdivision shall be reduced by any income from substitute work actually performed by the injured person or by income the injured person would have earned in available appropriate substitute work which the injured person was capable of performing but unreasonably failed to undertake.

(d) For the purposes of this section "inability to work" means disability which prevents the injured person from engaging in any substantial gainful occupation or employment on a regular basis, for wage or profit, for which the injured person is or may by training become reasonably qualified. If the injured person returns to employment and is unable by reason of the injury to work continuously, compensation for lost income shall be reduced by the income received while the injured person is actually able to work. The weekly maximums may not be prorated to arrive at a daily maximum, even if the injured person does not incur loss of income for a full week.

(e) For the purposes of this section, an injured person who is "unable by reason of the injury to work continuously" includes, but is not limited to, a person who misses time from work, including reasonable travel time, and loses income, vacation, or sick leave benefits, to obtain medical treatment for an injury arising out of the maintenance or use of a motor vehicle.

Sec. 9. Minnesota Statutes 2012, section 65B.44, subdivision 4, is amended to read:

Subd. 4. **Funeral and burial expenses.** Funeral and burial benefits shall be reasonable expenses not in excess of ~~$2,000~~ $5,000, including expenses for cremation or delivery under the Darlene Luther Revised Uniform Anatomical Gift Act, chapter 525A.

Sec. 10. Minnesota Statutes 2012, section 65B.44, subdivision 6, is amended to read:

Subd. 6. **Survivors economic loss benefits.** Survivors economic loss benefits, in the event of death occurring within one year of the date of the accident, caused by and arising out of injuries received in the accident, are subject to a maximum of ~~$200~~ $500 per week and shall cover loss accruing after decedent's death of contributions of money or tangible things of economic value, not including services, that surviving dependents

would have received from the decedent for their support during their dependency had the decedent not suffered the injury causing death.

For the purposes of definition under sections 65B.41 to 65B.71, the following described persons shall be presumed to be dependents of a deceased person: (a) a wife is dependent on a husband with whom she lives at the time of his death; (b) a husband is dependent on a wife with whom he lives at the time of her death; (c) any child while under the age of 18 years, or while over that age but physically or mentally incapacitated from earning, is dependent on the parent with whom the child is living or from whom the child is receiving support regularly at the time of the death of such parent; or (d) an actual dependent who lives with the decedent at the time of the decedent's death. Questions of the existence and the extent of dependency shall be questions of fact, considering the support regularly received from the deceased.

Payments shall be made to the dependent, except that benefits to a dependent who is a child or an incapacitated person may be paid to the dependent's surviving parent or guardian. Payments shall be terminated whenever the recipient ceases to maintain a status which if the decedent were alive would be that of dependency.

Sec. 11. Minnesota Statutes 2012, section 65B.525, is amended by adding a subdivision to read:

Subd. 3. **Awards.** The rules of court must provide that a party claiming economic loss benefits shall appear at the arbitration proceeding to be awarded any benefits.

Sec. 12. Minnesota Statutes 2012, section 65B.54, subdivision 2, is amended to read:

Subd. 2. **Interest on overdue payments.** Overdue payments shall bear simple interest at the rate of 15 percent per annum. Once an obligor has denied benefits from a specific provider, made a blanket denial of a type of benefits, or issued a general denial of benefits, interest is due on all overdue benefits within the scope of the denial, regardless of whether the insured or provider continues to provide ongoing proof of the fact and amount of each additional loss incurred.

Sec. 13. Minnesota Statutes 2012, section 72A.502, subdivision 2, is amended to read:

Subd. 2. **Prevention of fraud.** Personal or privileged information may be disclosed without a written authorization to another person if the information is limited to that which is reasonably necessary to detect or prevent criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with an insurance transaction, and that person agrees not to disclose the information further without the individual

written authorization unless the further disclosure is otherwise permitted by this section if made by an insurer, insurance agent, or insurance-support organization. Any insurer, insurance agent, or insurance-support organization making such a disclosure is immune from liability under section 60A.952, subdivision 3.

Sec. 14. **TASK FORCE ON MOTOR VEHICLE INSURANCE COVERAGE VERIFICATION.**

Subdivision 1. **Establishment.** The task force on motor vehicle insurance coverage verification is established to review and evaluate approaches to insurance coverage verification and recommend legislation to create and fund a program in this state.

Subd. 2. **Membership; meetings; staff.** (a) The task force shall be composed of 13 members, who must be appointed by July 1, 2014, and who serve at the pleasure of their appointing authorities:

(1) the commissioner of public safety or a designee;

(2) the commissioner of commerce or a designee;

(3) two members of the house of representatives, one appointed by the speaker of the house and one appointed by the minority leader;

(4) two members of the senate, one appointed by the Subcommittee on Committees of the Committee on Rules and Administration and one appointed by the minority leader;

(5) a representative of Minnesota Deputy Registrars Association;

(6) a representative of AAA Minnesota;

(7) a representative of AARP Minnesota;

(8) a representative of the Insurance Federation;

(9) a representative of the Minnesota Bankers Association;

(10) a representative of the Minnesota Bar Association; and

(11) a representative of the Minnesota Police and Peace Officers Association.

(b) Compensation and expense reimbursement must be as provided under Minnesota Statutes, section 15.059, subdivision 3, to members of the task force.

(c) The commissioner of public safety shall convene the task force by August 1, 2014, and shall appoint a chair from the membership of the task force. Staffing and technical assistance must be provided by the Department of Public Safety.

Subd. 3. **Duties.** The task force shall review and evaluate programs established in other states as well as programs proposed by third parties, identify one or more programs recommended for implementation in this state, and, as to the recommended programs, adopt findings concerning:

(1) comparative costs of programs;

(2) implementation considerations, and in particular, identifying the appropriate supervising agency and assessing compatibility with existing and planned computer systems;

(3) effectiveness in verifying existence of motor vehicle insurance coverage;

(4) identification of categories of authorized users;

(5) simplicity of access and use for authorized users;

(6) data privacy considerations;

(7) data retention policies; and

(8) statutory changes necessary for implementation.

Subd. 4. **Report.** By February 1, 2015, the task force must submit to the chairs and ranking minority members of the house of representatives and senate committees and divisions with primary jurisdiction over commerce and transportation its written recommendations, including any draft legislation necessary to implement the recommendations.

Subd. 5. **Sunset.** The task force shall sunset the day after submitting the report under subdivision 4, or February 2, 2015, whichever is earlier.

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

Sec. 15. **REPEALER.**

Minnesota Statutes 2012, section 72A.327, is repealed.

72A.327 HEALTH CLAIMS; RIGHTS OF APPEAL.

(a) An insured whose claim for medical benefits under chapter 65B is denied because the treatment or services for which the claim is made is claimed to be experimental, investigative, not medically necessary, or otherwise not generally accepted by licensed health care providers and for which the insured has financial responsibility in excess of applicable co-payments and deductibles may appeal the denial to the commissioner.

(b) This section does not apply to claims for health benefits which have been arbitrated under section 65B.525, subdivision 1.

(c) A three-member panel shall review the denial of the claim and report to the commissioner. The commissioner shall establish a list of qualified individuals who are eligible to serve on the panel. In establishing the list, the commissioner shall consult with representatives of the contributing members as defined in section 65B.01, subdivision 2, and professional societies. Each panel must include: one person with medical expertise as identified by the contributing members; one person with medical expertise as identified by the professional societies; and one public member. The commissioner, upon initiation of an arbitration, shall select from each list three potential arbitrators and shall notify the issuer and the claimant of the selection. Each party shall strike one of the potential arbitrators and an arbitrator shall be selected by the commissioner from the remaining names of potential arbitrators if more than one potential arbitrator is left. In the event of multiparty arbitration, the commissioner may increase the number of potential arbitrators and divide the strikes so as to afford an equal number of strikes to each adverse interest. If the selected arbitrator is unable or unwilling to serve for any reason, the commissioner may appoint an arbitrator, which will be subject to challenge only for cause. The party that denied the coverage has the burden of proving that the services or treatment are experimental, investigative, not medically necessary, or not generally accepted by licensed health care professionals. In determining whether the burden has been met, the panel may consider expert testimony, medical literature, and any other relevant sources. If the party fails to sustain its burden, the commissioner may order the immediate payment of the claim. All proceedings of the panel and any documents received or developed by the review process are nonpublic.

(d) A person aggrieved by an order under this section may appeal the order. The appeal shall be pursuant to section 65B.525 where appropriate, or to the district court for a trial de novo, in all other cases. In nonemergency situations, if the insurer has an internal grievance or appeal process, the insured must exhaust that process before the external appeal. In no event shall the internal grievance process exceed the time limits described in section 72A.201, subdivision 4a.

(e) If prior authorization is required before services or treatment can be rendered, an appeal of the denial of prior authorization may be made as provided in this section.

(f) The commissioner shall adopt procedural rules for the conduct of appeals.

(g) The permanent rulemaking authority granted in this section is effective June 2, 1989, regardless of the actual effective date of January 1, 1990.