

CHAPTER 77—S.F.No. 1998

An act relating to health; assessing health maintenance organizations for purposes of the insurance fraud prevention account; regulating certain rates, claims, filing, and reporting practices; eliminating expanded provider network requirements; amending Minnesota Statutes 2004, sections 45.0135, subdivision 7; 62E.05, subdivision 2; 62L.08, subdivision 8; 62Q.75; 72A.201, subdivision 4; 256B.692, subdivision 2; 295.582; repealing Minnesota Statutes 2004, sections 62E.035; 62Q.095.

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

Section 1. Minnesota Statutes 2004, section 45.0135, subdivision 7, is amended to read:

Subd. 7. **ASSESSMENT.** Each insurer authorized to sell insurance in the state of Minnesota shall remit an assessment to the commissioner for deposit in the insurance fraud prevention account on or before June 1 of each year. The amount of the assessment shall be based on the insurer's total assets and on the insurer's total written Minnesota premium, for the preceding fiscal year, as reported pursuant to section 60A.13. The assessment is calculated as follows:

Total Assets	Assessment
Less than \$100,000,000	\$ 200
\$100,000,000 to \$1,000,000,000	\$ 750
Over \$1,000,000,000	\$2,000
Minnesota Written Premium	Assessment
Less than \$10,000,000	\$ 200
\$10,000,000 to \$100,000,000	\$ 750
Over \$100,000,000	\$2,000

For purposes of this subdivision, the following entities are not considered to be insurers authorized to sell insurance in the state of Minnesota: risk retention groups; or township mutuals organized under chapter 67A; or health maintenance organizations organized under chapter 62D.

Sec. 2. Minnesota Statutes 2004, section 62E.05, subdivision 2, is amended to read:

Subd. 2. **ANNUAL REPORT.** (a) All health plan companies, as defined in section 62Q.01, shall annually report to the commissioner responsible for their regulation. The following information shall be reported to the appropriate commissioner on February 1 of each year:

(1) the number of individuals and groups who received coverage in the prior year through the qualified plans; and

(2) the number of individuals and groups who received coverage in the prior year through each of the unqualified plans sold by the company.

(b) The state of Minnesota or any of its departments, agencies, programs, instrumentalities, or political subdivisions, shall report in writing to the association and

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to the commissioner of commerce no later than September 15 of each year regarding the number of persons and the amount of premiums, deductibles, co-payments, or coinsurance that it paid for on behalf of enrollees in the Comprehensive Health Association. This report must contain only summary information and must not include any individually identifiable data. The report must cover the 12-month period ending the preceding June 30.

Sec. 3. Minnesota Statutes 2004, section 62L.08, subdivision 8, is amended to read:

Subd. 8. **FILING REQUIREMENT.** ~~No later than July 1, 1993, and each year thereafter,~~ A health carrier that offers, sells, issues, or renews a health benefit plan for small employers shall file with the commissioner the index rates and must demonstrate that all rates shall be within the rating restrictions defined in this chapter. Such demonstration must include the allowable range of rates from the index rates and a description of how the health carrier intends to use demographic factors including case characteristics in calculating the premium rates. The rates shall not be approved, unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b), to the calendar year or years that the proposed premium rate would be in effect, actuarially valid changes in risk associated with the enrollee population, and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549. ~~For premium rates proposed to go into effect between July 1, 1993 and December 31, 1993, the pertinent growth rate is the growth rate applied under section 62J.04, subdivision 1, paragraph (b), to calendar year 1994.~~

Sec. 4. Minnesota Statutes 2004, section 62Q.75, is amended to read:

62Q.75 PROMPT PAYMENT REQUIRED.

Subdivision 1. **DEFINITIONS.** (a) For purposes of this section, the following terms have the meanings given to them.

(b) "Clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, including, but not limited to, coordination of benefits information, or particular circumstance requiring special treatment that prevents timely payment from being made on a claim under this section. Nothing in this section alters an enrollee's obligation to disclose information as required by law.

(c) "Third-party administrator" means a third-party administrator or other entity subject to section 60A.23, subdivision 8, and Minnesota Rules, chapter 2767.

Subd. 2. **CLAIMS PAYMENTS.** (a) This section applies to clean claims submitted to a health plan company or third-party administrator for services provided by any:

(1) health care provider, as defined in section 62Q.74, but does not include a provider licensed under chapter 151;

(2) home health care provider, as defined in section 144A.43, subdivision 4; or

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(3) health care facility.

All health plan companies and third-party administrators must pay or deny claims that are clean claims within 30 calendar days after the date upon which the health plan company or third-party administrator received the claim.

(b) The health plan company or third-party administrator shall, upon request, make available to the provider information about the status of a claim submitted by the provider consistent with section 62J.581.

(c) If a health plan company or third-party administrator does not pay or deny a clean claim within the period provided in paragraph (a), the health plan company or third-party administrator must pay interest on the claim for the period beginning on the day after the required payment date specified in paragraph (a) and ending on the date on which the health plan company or third-party administrator makes the payment or denies the claim. In any payment, the health plan company or third-party administrator must itemize any interest payment being made separately from other payments being made for services provided. The health plan company or third-party administrator shall not require the health care provider to bill the health plan company or third-party administrator for the interest required under this section before any interest payment is made. Interest payments must be made to the health care provider no less frequently than quarterly.

(d) The rate of interest paid by a health plan company or third-party administrator under this subdivision shall be 1.5 percent per month or any part of a month.

(e) A health plan company or third-party administrator is not required to make an interest payment on a claim for which payment has been delayed for purposes of reviewing potentially fraudulent or abusive billing practices.

(f) The commissioner may assess a financial administrative penalty against a health plan company for violation of this subdivision when there is a pattern of abuse that demonstrates a lack of good faith effort and a systematic failure of the health plan company to comply with this subdivision.

Subd. 3. CLAIMS FILING. Unless otherwise provided by contract, by section 16A.124, subdivision 4a, or by federal law, the health care providers and facilities specified in subdivision 2, must submit their charges to a health plan company or third-party administrator within six months from the date of service or the date the health care provider knew or was informed of the correct name and address of the responsible health plan company or third-party administrator, whichever is later. A health care provider or facility that does not make an initial submission of charges within the six-month period shall not be reimbursed for the charge and may not collect the charge from the recipient of the service or any other payer. The six-month submission requirement may be extended to 12 months in cases where a health care provider or facility specified in subdivision 2 has determined and can substantiate that it has experienced a significant disruption to normal operations that materially affects the ability to conduct business in a normal manner and to submit claims on a timely basis. This subdivision also applies to all health care providers and facilities that

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submit charges to workers' compensation payers for treatment of a workers' compensation injury compensable under chapter 176, or to reparation obligors for treatment of an injury compensable under chapter 65B.

Sec. 5. Minnesota Statutes 2004, section 72A.201, subdivision 4, is amended to read:

Subd. 4. **STANDARDS FOR CLAIM FILING AND HANDLING.** The following acts by an insurer, an adjuster, a self-insured, or a self-insurance administrator constitute unfair settlement practices:

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

(i) the telephone number called, if any;

(ii) the name of the person making the telephone call or oral contact;

(iii) the name of the person who actually received the telephone call or oral contact;

(iv) the time of the telephone call or oral contact; and

(v) the date of the telephone call or oral contact;

(2) failing to reply, within ten business days of receipt, to all other communications about a claim from an insured or a claimant that reasonably indicate a response is requested or needed;

(3)(i) unless provided otherwise by clause (ii) or (iii), other law, or in the policy, failing to complete its investigation and inform the insured or claimant of acceptance or denial of a claim within 30 business days after receipt of notification of claim unless the investigation cannot be reasonably completed within that time. In the event that the investigation cannot reasonably be completed within that time, the insurer shall notify the insured or claimant within the time period of the reasons why the investigation is not complete and the expected date the investigation will be complete. For claims made under a health policy the notification of claim must be in writing;

(ii) for claims submitted under a health policy, the insurer must comply with all of the requirements of section 62Q.75;

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(iii) for claims submitted under a health policy that are accepted, the insurer must notify the insured or claimant no less than semiannually of the disposition of claims of the insured or claimant. For purposes of this clause, acceptance of a claim means that there is no additional financial liability for the insured or claimant, either because there is a flat co-payment amount specified in the health plan or because there is no co-payment, deductible, or coinsurance owed;

(4) where evidence of suspected fraud is present, the requirement to disclose their reasons for failure to complete the investigation within the time period set forth in clause (3) need not be specific. The insurer must make this evidence available to the Department of Commerce if requested;

(5) failing to notify an insured who has made a notification of claim of all available benefits or coverages which the insured may be eligible to receive under the terms of a policy and of the documentation which the insured must supply in order to ascertain eligibility;

(6) unless otherwise provided by law or in the policy, requiring an insured to give written notice of loss or proof of loss within a specified time, and thereafter seeking to relieve the insurer of its obligations if the time limit is not complied with, unless the failure to comply with the time limit prejudices the insurer's rights and then only if the insurer gave prior notice to the insured of the potential prejudice;

(7) advising an insured or a claimant not to obtain the services of an attorney or an adjuster, or representing that payment will be delayed if an attorney or an adjuster is retained by the insured or the claimant;

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

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

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

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

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

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

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

Sec. 6. Minnesota Statutes 2004, section 256B.692, subdivision 2, is amended to read:

Subd. 2. **DUTIES OF THE COMMISSIONER OF HEALTH.** (a) Notwithstanding chapters 62D and 62N, a county that elects to purchase medical assistance and general assistance medical care in return for a fixed sum without regard to the frequency or extent of services furnished to any particular enrollee is not required to obtain a certificate of authority under chapter 62D or 62N. The county board of commissioners is the governing body of a county-based purchasing program. In a multicounty arrangement, the governing body is a joint powers board established under section 471.59.

(b) A county that elects to purchase medical assistance and general assistance medical care services under this section must satisfy the commissioner of health that the requirements for assurance of consumer protection, provider protection, and fiscal solvency of chapter 62D, applicable to health maintenance organizations, or chapter 62N, applicable to community integrated service networks, will be met.

(c) A county must also assure the commissioner of health that the requirements of sections 62J.041; 62J.48; 62J.71 to 62J.73; 62M.01 to 62M.16; all applicable provisions of chapter 62Q, including sections 62Q.075; 62Q.1055; 62Q.106; 62Q.12; 62Q.135; 62Q.14; 62Q.145; 62Q.19; 62Q.23, paragraph (c); 62Q.43; 62Q.47; 62Q.50; 62Q.52 to 62Q.56; 62Q.58; 62Q.64; 62Q.68 to 62Q.72; and 72A.201 will be met.

(d) All enforcement and rulemaking powers available under chapters 62D, 62J, 62M, 62N, and 62Q are hereby granted to the commissioner of health with respect to counties that purchase medical assistance and general assistance medical care services under this section.

(e) The commissioner, in consultation with county government, shall develop administrative and financial reporting requirements for county-based purchasing programs relating to sections 62D.041, 62D.042, 62D.045, 62D.08, 62N.28, 62N.29, and 62N.31, and other sections as necessary, that are specific to county administrative, accounting, and reporting systems and consistent with other statutory requirements of counties.

Sec. 7. Minnesota Statutes 2004, section 295.582, is amended to read:

295.582 AUTHORITY.

(a) A hospital, surgical center, or health care provider that is subject to a tax under section 295.52, or a pharmacy that has paid additional expense transferred under this section by a wholesale drug distributor, may transfer additional expense generated by

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section 295.52 obligations on to all third-party contracts for the purchase of health care services on behalf of a patient or consumer. The additional expense transferred to the third-party purchaser must not exceed the tax percentage specified in section 295.52 multiplied against the gross revenues received under the third-party contract, and the tax percentage specified in section 295.52 multiplied against co-payments and deductibles paid by the individual patient or consumer. The expense must not be generated on revenues derived from payments that are excluded from the tax under section 295.53. All third-party purchasers of health care services including, but not limited to, third-party purchasers regulated under chapter 60A, 62A, 62C, 62D, 62H, 62N, 64B, 65A, 65B, 79, or 79A, or under section 471.61 or 471.617, must pay the transferred expense in addition to any payments due under existing contracts with the hospital, surgical center, pharmacy, or health care provider, to the extent allowed under federal law. A third-party purchaser of health care services includes, but is not limited to, a health carrier or community integrated service network that pays for health care services on behalf of patients or that reimburses, indemnifies, compensates, or otherwise insures patients for health care services. A third-party purchaser shall comply with this section regardless of whether the third-party purchaser is a for-profit, not-for-profit, or nonprofit entity. A wholesale drug distributor may transfer additional expense generated by section 295.52 obligations to entities that purchase from the wholesaler, and the entities must pay the additional expense. Nothing in this section limits the ability of a hospital, surgical center, pharmacy, wholesale drug distributor, or health care provider to recover all or part of the section 295.52 obligation by other methods, including increasing fees or charges.

(b) ~~Each third-party purchaser regulated under any chapter cited in paragraph (a) shall include with its annual renewal for certification of authority or licensure documentation indicating compliance with paragraph (a).~~

(e) Any hospital, surgical center, or health care provider subject to a tax under section 295.52 or a pharmacy that has paid additional expense transferred under this section by a wholesale drug distributor may file a complaint with the commissioner responsible for regulating the third-party purchaser if at any time the third-party purchaser fails to comply with paragraph (a).

(d) (c) If the commissioner responsible for regulating the third-party purchaser finds at any time that the third-party purchaser has not complied with paragraph (a), the commissioner may take enforcement action against a third-party purchaser which is subject to the commissioner's regulatory jurisdiction and which does not allow a hospital, surgical center, pharmacy, or provider to pass-through the tax. The commissioner may by order fine or censure the third-party purchaser or revoke or suspend the certificate of authority or license of the third-party purchaser to do business in this state if the commissioner finds that the third-party purchaser has not complied with this section. The third-party purchaser may appeal the commissioner's order through a contested case hearing in accordance with chapter 14.

Sec. 8. **REPEALER.**

Minnesota Statutes 2004, sections 62E.035 and 62Q.095, are repealed.

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Presented to the governor May 20, 2005

Signed by the governor May 24, 2005, 1:55 p.m.

CHAPTER 78—S.F.No. 1335

An act relating to state government; regulating state construction contracts; amending Minnesota Statutes 2004, sections 16B.31, subdivision 1; 16B.33, subdivision 1; 16C.26, subdivisions 3, 4; 16C.28, subdivision 2; proposing coding for new law in Minnesota Statutes, chapter 16C.

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

Section 1. Minnesota Statutes 2004, section 16B.31, subdivision 1, is amended to read:

Subdivision 1. **CONSTRUCTION PLANS AND SPECIFICATIONS; DESIGN-BUILD, CONSTRUCTION MANAGER AT RISK, OR JOB ORDER CONTRACTING.** (a) The commissioner shall (1) have plans and specifications prepared for the construction, alteration, or enlargement of all state buildings, structures, and other improvements except highways and bridges, and except for buildings and structures under the control of the Board of Regents of the University of Minnesota or of the Board of Trustees of the Minnesota State Colleges and Universities; (2) approve those plans and specifications; (3) advertise for bids and award all contracts in connection with the improvements; (4) supervise and inspect all work relating to the improvements; (5) approve all lawful changes in plans and specifications after the contract for an improvement is let; and (6) approve estimates for payment. This subdivision does not apply to the construction of the Zoological Gardens.

(b) MS 2002 (Expired)

(c) MS 2002 (Expired)

(b) Notwithstanding any other law to the contrary, the commissioner may:

(1) use a design-build method of project delivery and award a design-build contract as provided in sections 16C.32 and 16C.33;

(2) use a construction manager at risk method of project delivery and award a construction manager at risk contract on the basis of the selection criteria described in section 16C.34; or

(3) use a job order contracting contractor selection as described in section 16C.35.

(c) The commissioner may require a primary designer and a construction manager at risk, by contract, to cooperate in the design, planning and scheduling, and construction process. The contract must not make the primary designer or construction

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