CHAPTER 62Q

REQUIREMENTS FOR HEALTH PLAN COMPANIES

62Q.01 DEFINITIONS.

[For text of subds 1 to 5, see M.S.2004]

Subd. 6. **Medicare-related coverage.** "Medicare-related coverage" means a policy, contract, or certificate issued as a supplement to Medicare, regulated under sections 62A.31 to 62A.44, including Medicare select coverage; policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations; or policies, contracts, or certificates governed by sections 1833 (known as "cost" or "HCPP" contracts), 1851 to 1859 (Medicare Advantage), 1860D (Medicare Part D), or 1876 (known as "TEFRA" or "risk" contracts) of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended; or Section 4001 of the Balanced Budget Act of 1997 (BBA)(Public Law 105-33), Sections 1851 to 1859 of the Social Security Act establishing Part C of the Medicare program, known as the "Medicare Advantage program."

History: *2005 c 17 art 3 s 2*

62Q.075 LOCAL PUBLIC ACCOUNTABILITY AND COLLABORATION PLAN.

Subd. 2. **Requirement.** Beginning October 31, 2004, all health maintenance organizations shall file a plan every four years with the commissioner of health describing the actions the health maintenance organization intends to take to contribute to achieving one or more high priority public health goals. This plan must be jointly developed in collaboration with the local public health units, and other community organizations providing health services within the same service area as the health maintenance organization. Local government units with responsibilities and authority defined under chapter 145A may designate individuals to participate in the collaborative planning with the health maintenance organization to provide expertise and represent community needs and goals as identified under chapter 145A. Every other year, beginning October 31, 2002, all health maintenance organizations shall file reports updating progress on the four-year collaboration plan.

[For text of subd 3, see M.S.2004]

Subd. 4. **Review.** Upon receipt of the plan, the commissioner of health shall provide a copy to the local community health boards, and other relevant community organizations within the health maintenance organization's service area. After reviewing the plan, these community groups may submit written comments on the plan to the commissioner of health and may advise the commissioner of the health maintenance organization's effectiveness in assisting to achieve high priority public health goals. The plan may be reviewed by the county boards, or city councils acting as a local board of health in accordance with chapter 145A, within the health maintenance organization's service area to determine whether the plan is consistent with the goals and objectives of the plans required under chapter 145A and whether the plan meets the needs of the community. The county board, or applicable city council, may also review and make recommendations on the availability and accessibility of services provided by the health maintenance organization. The county board, or applicable city council, may submit written comments to the commissioner of health, and may advise the commissioner of the health maintenance organization's effectiveness in assisting to meet the needs and

goals as defined under the responsibilities of chapter 145A. Copies of these written comments must be provided to the health maintenance organization. The plan and any comments submitted must be filed with the information clearinghouse to be distributed to the public.

History: *2005 c 98 art 3 s 24*

62Q.095 [Repealed, 2005 c 77 s 8]

62Q.251 DISCOUNTED PAYMENTS.

(a) Notwithstanding any other provision of law, a health care provider may provide care to a patient at a discounted payment amount.

(b) A health plan company or other insurer must not consider, in determining a provider's usual and customary payment, standard payment, or allowable payment used as a basis for determining the provider's payment by the health plan company or other insurer, the following discounted payment situations:

(1) care provided to relatives of the provider;

(2) care for which a discount is given for hardship situations; and

(3) care for which a discount is given in exchange for cash payment.

(c) Nothing in this section shall prohibit a provider from providing charity care for hardship situations in which the care is provided for free.

History: *2005 c 147 art 11 s 3; 1Sp2005 c 4 art 8 s 3*

62Q.37 AUDITS CONDUCTED BY NATIONALLY RECOGNIZED INDEPENDENT ORGANIZATION.

[For text of subds 1 to 6, see M.S.2004]

Subd. 7. **Human services.** (a) The commissioner of human services shall implement this section in a manner that is consistent with applicable federal laws and regulations and that avoids the duplication of review activities performed by a nationally recognized independent organization.

(b) By December 31 of each year, the commissioner shall submit to the legislature a written report identifying the number of audits performed by a nationally recognized independent organization that were accepted, partially accepted, or rejected by the commissioner under this section. The commissioner shall provide the rationale for partial acceptance or rejection. If the rationale for the partial acceptance or rejection was based on the commissioner's determination that the standards used in the audit were not equivalent to state law, regulation, or contract requirement, the report must document the variances between the audit standards and the applicable state requirements.

[For text of subd 8, see M.S.2004]

History: *1Sp2005 c 4 art 8 s 4*

62Q.471 EXCLUSION FOR SUICIDE ATTEMPTS PROHIBITED.

(a) No health plan may exclude or reduce coverage for health care for an enrollee who is otherwise covered under the health plan on the basis that the need for the health care arose out of a suicide or suicide attempt by the enrollee.

(b) For purposes of this section, "health plan" has the meaning given in section 62Q.01, subdivision 3, but includes the coverages described in section 62A.011, clauses (4), (6), and (7) through (10).

History: *2005 c 132 s 16*

62Q.65 ACCESS TO PROVIDER DISCOUNTS.

Subdivision 1. **Requirement.** A high deductible health plan must, when used in connection with a medical savings account or health savings account, provide the

enrollee access to any discounted provider fees for services covered by the high deductible health plan, regardless of whether the enrollee has satisfied the deductible for the high deductible health plan.

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given:

(1) "high deductible health plan" has the meaning given under the Internal Revenue Code of 1986, section 220(c)(2), with respect to a medical savings account; and the meaning given under Internal Revenue Code of 1986, section 223(c)(2), with respect to a health savings account;

(2) "medical savings account" has the meaning given under the Internal Revenue Code of 1986, section 220(d)(1);

(3) "discounted provider fees" means fees contained in a provider agreement entered into by the issuer of the high deductible health plan, or an affiliate of the issuer, for use in connection with the high deductible health plan; and

(4) "health savings account" has the meaning given under the Internal Revenue Code of 1986, section 223(d).

History: *2005 c 132 s 17*

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

(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 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.

History: *2005 c 77 s 4*