State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-SEVENTH SESSION

H. F. No. 2412

02/20/2012 Authored by Gottwalt, Laine, Hosch, Scott, Lohmer and others
The bill was read for the first time and referred to the Committee on Health and Human Services Reform
02/29/2012 Adoption of Report: Pass as Amended and re-referred to the Committee on Health and Human Services Finance
03/30/2012 Adoption of Report: Pass as Amended and Read Second Time

A bill for an act

relating to health; requiring certain changes in managed care plan financial reporting; requiring an annual independent third-party audit; eliminating and modifying reporting requirements; amending Minnesota Statutes 2010, sections 72A.201, subdivision 8; 256B.69, by adding a subdivision; Minnesota Statutes 2011 Supplement, section 256B.69, subdivision 9c; repealing Minnesota Statutes 2010, sections 62M.09, subdivision 9; 62Q.64; Minnesota Rules, part 4685.2000.

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

Section 1. Minnesota Statutes 2010, section 72A.201, subdivision 8, is amended to read:

Subd. 8. **Standards for claim denial.** The following acts by an insurer, adjuster, or self-insured, or self-insurance administrator constitute unfair settlement practices:

(1) denying a claim or any element of a claim on the grounds of a specific policy provision, condition, or exclusion, without informing the insured of the policy provision, condition, or exclusion on which the denial is based;

(2) denying a claim without having made a reasonable investigation of the claim;

(3) denying a liability claim because the insured has requested that the claim be denied;

(4) denying a liability claim because the insured has failed or refused to report the claim, unless an independent evaluation of available information indicates there is no liability;

(5) denying a claim without including the following information:

(i) the basis for the denial;

(ii) the name, address, and telephone number of the insurer's claim service office or the claim representative of the insurer to whom the insured or claimant may take any questions or complaints about the denial;

(iii) the claim number and the policy number of the insured; and

(iv) if the denied claim is a fire claim, the insured's right to file with the Department of Commerce a complaint regarding the denial, and the address and telephone number of the Department of Commerce;

(6) denying a claim because the insured or claimant failed to exhibit the damaged property unless:

(i) the insurer, within a reasonable time period, made a written demand upon the insured or claimant to exhibit the property; and

(ii) the demand was reasonable under the circumstances in which it was made;

(7) denying a claim by an insured or claimant based on the evaluation of a chemical dependency claim reviewer selected by the insurer unless the reviewer meets the qualifications specified under subdivision 8a. An insurer that selects chemical dependency reviewers to conduct claim evaluations must annually file with the commissioner of commerce a report containing the specific evaluation standards and criteria used in these evaluations. The report must be filed at the same time its annual statement is submitted under section 60A.13. ~~The report must also include the number of evaluations performed on behalf of the insurer during the reporting period, the types of evaluations performed, the results, the number of appeals of denials based on these evaluations, the results of these appeals, and the number of complaints filed in a court of competent jurisdiction.~~

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

Sec. 2. Minnesota Statutes 2011 Supplement, section 256B.69, subdivision 9c, is amended to read:

Subd. 9c. **Managed care financial reporting.** (a) The commissioner shall collect detailed data regarding financials, provider payments, provider rate methodologies, and other data as determined by the commissioner and managed care and county-based purchasing plans that are required to be submitted under this section. The commissioner, in consultation with the commissioners of health and commerce, and in consultation with managed care plans and county-based purchasing plans, shall set uniform criteria, definitions, and standards for the data to be submitted, and shall require managed care and county-based purchasing plans to comply with these criteria, definitions, and standards when submitting data under this section. In carrying out the responsibilities of this subdivision, the commissioner shall ensure that the data collection is implemented in an

integrated and coordinated manner that avoids unnecessary duplication of effort. To the extent possible, the commissioner shall use existing data sources and streamline data collection in order to reduce public and private sector administrative costs. Nothing in this subdivision shall allow release of information that is nonpublic data pursuant to section 13.02.

(b) Each managed care and county-based purchasing plan must annually provide to the commissioner the following information on state public programs, in the form and manner specified by the commissioner, according to guidelines developed by the commissioner in consultation with managed care plans and county-based purchasing plans under contract:

(1) administrative expenses by category and subcategory consistent with administrative expense reporting to other state and federal regulatory agencies, by program;

(2) revenues by program, including investment income;

(3) nonadministrative service payments, provider payments, and reimbursement rates by provider type or service category, by program, paid by the managed care plan under this section or the county-based purchasing plan under section 256B.692 to providers and vendors for administrative services under contract with the plan, including but not limited to:

(i) individual-level provider payment and reimbursement rate data;

(ii) provider reimbursement rate methodologies by provider type, by program, including a description of alternative payment arrangements and payments outside the claims process;

(iii) data on implementation of legislatively mandated provider rate changes; and

(iv) individual-level provider payment and reimbursement rate data and plan-specific provider reimbursement rate methodologies by provider type, by program, including alternative payment arrangements and payments outside the claims process, provided to the commissioner under this subdivision are nonpublic data as defined in section 13.02;

(4) data on the amount of reinsurance or transfer of risk by program; and

(5) contribution to reserve, by program.

(c) In the event a report is published or released based on data provided under this subdivision, the commissioner shall provide the report to managed care plans and county-based purchasing plans 30 days prior to the publication or release of the report. Managed care plans and county-based purchasing plans shall have 30 days to review the report and provide comment to the commissioner.

(d) The legislative auditor shall contract for the audit required under this paragraph. The legislative auditor shall require, in the request for bids and the resulting contracts for coverage to be provided under this section, that each managed care and county-based purchasing plan submit to and fully cooperate with an annual independent third-party financial audit of the information required under paragraph (b). For purposes of this paragraph, "independent third party" means an audit firm that is independent in accordance with government auditing standards issued by the United State Government Accountability Office and licensed in accordance with chapter 326A. In no case shall the audit firm conducting the audit provide services to a managed care or county-based purchasing plan at the same time as the audit is being conducted or have provided services to a managed care or county-based purchasing plan during the prior three years.

(e) The audit of the information required under paragraph (b) shall be conducted by an independent third-party firm in accordance with generally accepted government auditing standards issued by the United States Government Accountability Office.

(f) A managed care or county-based purchasing plan that provides services under this section shall provide to the commissioner biweekly encounter and claims data at a detailed level, and shall participate in a quality assurance program that verifies the timeliness, completeness, accuracy, and consistency of data provided. The commissioner shall have written protocols for the quality assurance program that are publicly available. The commissioner shall contract with an independent third-party auditing firm to evaluate the quality assurance protocols, the capacity of those protocols to assure complete and accurate data, and the commissioner's implementation of the protocols.

(g) Contracts awarded under this section to a managed care or county-based purchasing plan must provide that the commissioner and the contracted auditor shall have unlimited access to any and all data required to complete the audit and that this access shall be enforceable in a court of competent jurisdiction through the process of injunctive or other appropriate relief.

(h) No actuary or actuarial firm providing actuarial services to the commissioner in connection with this subdivision shall provide services to any managed care or county-based purchasing plan participating in this subdivision during the term of the actuary's work for the commissioner under this subdivision.

(i) The actuary or actuarial firm referenced in paragraph (h) shall certify and attest to the rates paid to managed care plans and county-based purchasing plans under this section, and the certification and attestation must be auditable.

(j) The independent third-party audit shall include a determination of compliance with the federal Medicaid rate certification process.

(k) The legislative auditor's contract with the independent third-party auditing firm shall be designed and administered so as to render the independent third-party audit eligible for a federal subsidy if available for that purpose.

(l) Upon completion of the audit, and its receipt by the legislative auditor, the legislative auditor shall provide copies of the audit report to the commissioner, the state auditor, the attorney general, and the chairs and ranking minority members of the health finance committees of the legislature.

(m) The commissioner shall annually assess managed care and county-based purchasing plans for agency costs related to implementing paragraphs (d) to (l), which have been approved as reasonable by the commissioner of management and budget. The assessment for each plan shall be in proportion to that plan's share of total medical assistance and MinnesotaCare enrollment under this section and sections 256B.692 and 256L.12.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to contracts, and the contracting process, for contracts that are effective January 1, 2013, and thereafter.

Sec. 3. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision to read:

Subd. 9d. **Savings from report elimination.** Managed care and county-based purchasing plans shall use all savings resulting from the elimination or modification of reporting requirements under sections 1, 4, and 5 to pay the assessment required by subdivision 9c, paragraph (m).

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

Sec. 4. **REPORTING REQUIREMENTS.**

Subdivision 1. **Evidence-based childbirth program.** The commissioner of human services may discontinue the evidence-based childbirth program and shall discontinue all affiliated reporting requirements established under Minnesota Statutes, section 256B.0625, subdivision 3g, once the commissioner determines that hospitals representing at least 90 percent of births covered by medical assistance or MinnesotaCare have approved policies and processes in place that prohibit elective inductions prior to 39 weeks' gestation.

Subd. 2. **Provider networks.** The commissioners of health, commerce, and human services shall merge reporting requirements for health maintenance organizations and county-based purchasing plans related to Minnesota Department of Health oversight of

network adequacy under Minnesota Statutes, section 62D.124, and the provider network list reported to the Department of Human Services under Minnesota Rules, part 4685.2100. The commissioners shall work with health maintenance organizations and county-based purchasing plans to ensure that the report merger is done in a manner that simplifies health maintenance organization and county-based purchasing plan reporting processes.

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

Sec. 5. **REPEALER.**

Subdivision 1. **Summary of complaints and grievances.** Minnesota Rules, part 4685.2000, is repealed effective the day following final enactment.

Subd. 2. **Medical necessity denials and appeals.** Minnesota Statutes 2010, section 62M.09, subdivision 9, is repealed effective the day following final enactment.

Subd. 3. **Salary reports.** Minnesota Statutes 2010, section 62Q.64, is repealed effective the day following final enactment.

62M.09 STAFF AND PROGRAM QUALIFICATIONS; ANNUAL REPORT.

Subd. 9. **Annual report.** A utilization review organization shall file an annual report with the annual financial statement it submits to the commissioner of commerce that includes:

(1) per 1,000 utilization reviews, the number and rate of determinations not to certify based on medical necessity for each procedure or service; and

(2) the number and rate of denials overturned on appeal.

A utilization review organization that is not a licensed health carrier must submit the annual report required by this subdivision on April 1 of each year.

62Q.64 DISCLOSURE OF EXECUTIVE COMPENSATION.

(a) Each health plan company doing business in this state whose annual Minnesota premiums exceed $10,000,000 based on the most recent assessment base of the Minnesota Comprehensive Health Association shall annually file with either the commissioner of commerce or the commissioner of health, as appropriate:

(1) a copy of the health plan company's form 990 filed with the federal Internal Revenue Service; or

(2) if the health plan company did not file a form 990 with the federal Internal Revenue Service, a list of the amount and recipients of the health plan company's five highest salaries, including all types of compensation, in excess of $50,000.

(b) A filing under this section is public data under section 13.03.

4685.2000 COMPLAINT REPORTS.

Every health maintenance organization shall submit to the commissioner of health, along with its annual report, a report on the experience of its respective complaint system during the immediately preceding calendar year. Such reports shall include at least the following information:

A. the name and location of the reporting health maintenance organization;

B. the reporting period in question;

C. the name of the individual(s) responsible for the operation of the complaint system;

D. the total number of written complaints received by the health maintenance organization;

E. the total number of written complaints received, classified as to whether they were principally medical care, psychosocial, or coverage-related in nature, or classified according to a classification most suited to the characteristics of the particular health maintenance organization, unless unduly burdensome;

F. the number of enrollees by whom or for whom more than one written complaint was made and the total number of such complaints; and

G. the total number of written complaints resolved to the enrollee's apparent satisfaction.