SENATE
STATE OF MINNESOTA
EIGHTY-NINTH SESSION

S.F. No. 1113

(SENATE AUTHORS: LOUREY)

DATE	D-PG	OFFICIAL STATUS
02/26/2015	432	Introduction and first reading Referred to Commerce
03/11/2015	639a	Comm report: To pass as amended and re-refer to Finance See SF1458, Art. 11

A bill for an act

relating to state government; regulating insurance; requiring third-party payer payments within a certain time limit; requiring third-party payers to include certain information; establishing a long-term care call center; providing for the development of a life stage planning insurance product; amending Minnesota Statutes 2014, sections 62A.045; 256.015, subdivision 7; 256.975, subdivision 8.

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

Section 1. Minnesota Statutes 2014, section 62A.045, is amended to read:

62A.045 PAYMENTS ON BEHALF OF ENROLLEES IN GOVERNMENT HEALTH PROGRAMS.

(a) As a condition of doing business in Minnesota or providing coverage to residents of Minnesota covered by this section, each health insurer shall comply with the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171, including any federal regulations adopted under that act, to the extent that it imposes a requirement that applies in this state and that is not also required by the laws of this state. This section does not require compliance with any provision of the federal act prior to the effective date provided for that provision in the federal act. The commissioner shall enforce this section.

For the purpose of this section, "health insurer" includes self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are by contract legally responsible to pay a claim for a health-care item or service for an individual receiving benefits under paragraph (b).

(b) No plan offered by a health insurer issued or renewed to provide coverage to a Minnesota resident shall contain any provision denying or reducing benefits because services are rendered to a person who is eligible for or receiving medical benefits pursuant

to title XIX of the Social Security Act (Medicaid) in this or any other state; chapter 256; 256B; or 256D or services pursuant to section 252.27; 256L.01 to 256L.10; 260B.331, subdivision 2; 260C.331, subdivision 2; or 393.07, subdivision 1 or 2. No health insurer providing benefits under plans covered by this section shall use eligibility for medical programs named in this section as an underwriting guideline or reason for nonacceptance of the risk.

(c) If payment for covered expenses has been made under state medical programs for health care items or services provided to an individual, and a third party has a legal liability to make payments, the rights of payment and appeal of an adverse coverage decision for the individual, or in the case of a child their responsible relative or caretaker, will be subrogated to the state agency. The state agency may assert its rights under this section within three years of the date the service was rendered. For purposes of this section, "state agency" includes prepaid health plans under contract with the commissioner according to sections 256B.69, 256D.03, subdivision 4, paragraph (c), and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; and county-based purchasing entities under section 256B.692.

(d) Notwithstanding any law to the contrary, when a person covered by a plan offered by a health insurer receives medical benefits according to any statute listed in this section, payment for covered services or notice of denial for services billed by the provider must be issued directly to the provider. If a person was receiving medical benefits through the Department of Human Services at the time a service was provided, the provider must indicate this benefit coverage on any claim forms submitted by the provider to the health insurer for those services. If the commissioner of human services notifies the health insurer that the commissioner has made payments to the provider, payment for benefits or notices of denials issued by the health insurer must be issued directly to the commissioner. Submission by the department to the health insurer of the claim on a Department of Human Services claim form is proper notice and shall be considered proof of payment of the claim to the provider and supersedes any contract requirements of the health insurer relating to the form of submission. Liability to the insured for coverage is satisfied to the extent that payments for those benefits are made by the health insurer to the provider or the commissioner as required by this section.

(e) When a state agency has acquired the rights of an individual eligible for medical programs named in this section and has health benefits coverage through a health insurer, the health insurer shall not impose requirements that are different from requirements applicable to an agent or assignee of any other individual covered.

(f) A health insurer must process a claim made by a state agency for covered expenses paid under state medical programs within 90 business days of the claim's submission. If the health insurer needs additional information to process the claim, the health insurer may be granted an additional 30 business days to process the claim, provided the health insurer submits the request for additional information to the state agency within 30 business days after the health insurer received the claim.

(g) A health insurer may request a refund of a claim paid in error to the Department of Human Services within two years of the date the payment was made to the department. A request for a refund shall not be honored by the department if the health insurer makes the request after the time period has lapsed.

Sec. 2. Minnesota Statutes 2014, section 256.015, subdivision 7, is amended to read:

Subd. 7. **Cooperation with information requests required.** (a) Upon the request of the commissioner of human services:

(1) any state agency or third-party payer shall cooperate by furnishing information to help establish a third-party liability, as required by the federal Deficit Reduction Act of 2005, Public Law 109-171;

(2) any employer or third-party payer shall cooperate by furnishing a data file containing information about group health insurance plan or medical benefit plan coverage of its employees or insureds within 60 days of the request. The information in the data file must include at least the following: full name, date of birth, Social Security number if collected by the employer or third-party payer, employer name, policy identification number, group identification number, and plan or coverage type.

(b) For purposes of section 176.191, subdivision 4, the commissioner of labor and industry may allow the commissioner of human services and county agencies direct access and data matching on information relating to workers' compensation claims in order to determine whether the claimant has reported the fact of a pending claim and the amount paid to or on behalf of the claimant to the commissioner of human services.

(c) For the purpose of compliance with section 169.09, subdivision 13, and federal requirements under Code of Federal Regulations, title 42, section 433.138 (d)(4), the commissioner of public safety shall provide accident data as requested by the commissioner of human services. The disclosure shall not violate section 169.09, subdivision 13, paragraph (d).

(d) The commissioner of human services and county agencies shall limit its use of information gained from agencies, third-party payers, and employers to purposes directly connected with the administration of its public assistance and child support programs. The

provision of information by agencies, third-party payers, and employers to the department under this subdivision is not a violation of any right of confidentiality or data privacy.

Sec. 3. Minnesota Statutes 2014, section 256.975, subdivision 8, is amended to read:

Subd. 8. **~~Promotion of~~ Establish long-term care ~~insurance~~ call center.** Within the limits of appropriations specifically for this purpose, the Minnesota Board on Aging, ~~either directly or~~ through ~~contract,~~ its Senior LinkAge Line established under section 256.975, subdivision 7, shall ~~promote the provision of employer-sponsored,~~ establish a long-term care call center that promotes planning for long-term care and provides information about long-term care insurance, other long-term care financing options, and resources that support Minnesotans as they age or have more long-term chronic care needs. The board shall ~~encourage private and public sector employers to make long-term care insurance available to employees, provide interested employers with information on the long-term care insurance product offered to state employees, and provide~~ work with a variety of stakeholders, including employers, insurance providers, brokers, or other sellers of products and consumers to develop the call center. The board shall seek technical assistance ~~to employers in designing long-term care insurance products and contacting companies offering long-term care insurance products~~ from the commissioner for implementation of the call center.

Sec. 4. **DEVELOPMENT OF LONG-TERM CARE, LIFE STAGE PLANNING INSURANCE PRODUCT.**

The commissioner of human services, in consultation with members of the Own Your Future Advisory Council, the commissioner of commerce, and other stakeholders shall conduct research on the feasibility of creating a life stage planning insurance product that merges term life insurance with long-term care insurance coverage. The commissioner shall:

(1) conduct product evaluation research with consumers;

(2) conduct an actuarial analysis to evaluate likely levels for insurer pricing for the product;

(3) meet with insurance carriers to determine interest in pursuing the product;

(4) identify specific state laws and regulations that may need to be amended to make the product available; and

(5) develop one or more pilot programs to market test the product.