SENATE
STATE OF MINNESOTA
EIGHTY-SEVENTH LEGISLATURE

S.F. No. 745

(SENATE AUTHORS: LOUREY)

DATE	D-PG	OFFICIAL STATUS
03/10/2011	486	Introduction and first reading Referred to Health and Human Services

A bill for an act

relating to health care; providing an alternative mechanism for prompt payment of emergency room and ambulance charges incurred by patients enrolled in very high deductible health plans; amending Minnesota Statutes 2010, sections 60A.23, subdivision 8; 62Q.01, by adding a subdivision; 62Q.025, by adding a subdivision.

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

Section 1. Minnesota Statutes 2010, section 60A.23, subdivision 8, is amended to read:

Subd. 8. **Self-insurance or insurance plan administrators who are vendors of risk management services.** (1) **Scope.** This subdivision applies to any vendor of risk management services and to any entity which administers, for compensation, a self-insurance or insurance plan. This subdivision does not apply (a) to an insurance company authorized to transact insurance in this state, as defined by section 60A.06, subdivision 1, clauses (4) and (5); (b) to a service plan corporation, as defined by section 62C.02, subdivision 6; (c) to a health maintenance organization, as defined by section 62D.02, subdivision 4; (d) to an employer directly operating a self-insurance plan for its employees' benefits; (e) to an entity which administers a program of health benefits established pursuant to a collective bargaining agreement between an employer, or group or association of employers, and a union or unions; or (f) to an entity which administers a self-insurance or insurance plan if a licensed Minnesota insurer is providing insurance to the plan and if the licensed insurer has appointed the entity administering the plan as one of its licensed agents within this state.

(2) **Definitions.** For purposes of this subdivision the following terms have the meanings given them.

(a) "Administering a self-insurance or insurance plan" means (i) processing, reviewing or paying claims, (ii) establishing or operating funds and accounts, or (iii) otherwise providing necessary administrative services in connection with the operation of a self-insurance or insurance plan.

(b) "Employer" means an employer, as defined by section 62E.02, subdivision 2.

(c) "Entity" means any association, corporation, partnership, sole proprietorship, trust, or other business entity engaged in or transacting business in this state.

(d) "Self-insurance or insurance plan" means a plan for the benefit of employees or members of an association providing life, medical or hospital care, accident, sickness or disability insurance, or pharmacy benefits, or a plan providing liability coverage for any other risk or hazard, which is or is not directly insured or provided by a licensed insurer, service plan corporation, or health maintenance organization.

(e) "Vendor of risk management services" means an entity providing for compensation actuarial, financial management, accounting, legal or other services for the purpose of designing and establishing a self-insurance or insurance plan for an employer.

(3) **License.** No vendor of risk management services or entity administering a self-insurance or insurance plan may transact this business in this state unless it is licensed to do so by the commissioner. An applicant for a license shall state in writing the type of activities it seeks authorization to engage in and the type of services it seeks authorization to provide. The license may be granted only when the commissioner is satisfied that the entity possesses the necessary organization, background, expertise, and financial integrity to supply the services sought to be offered. The commissioner may issue a license subject to restrictions or limitations upon the authorization, including the type of services which may be supplied or the activities which may be engaged in. The license fee is $1,500 for the initial application and $1,500 for each three-year renewal. All licenses are for a period of three years.

(4) **Regulatory restrictions; powers of the commissioner.** To assure that self-insurance or insurance plans are financially solvent, are administered in a fair and equitable fashion, and are processing claims and paying benefits in a prompt, fair, and honest manner, vendors of risk management services and entities administering insurance or self-insurance plans are subject to the supervision and examination by the commissioner. Vendors of risk management services, entities administering insurance or self-insurance plans, and insurance or self-insurance plans established or operated by them are subject to the trade practice requirements of sections 72A.19 to 72A.30. In lieu of an unlimited guarantee from a parent corporation for a vendor of risk management services or an entity administering insurance or self-insurance plans, the commissioner

may accept a surety bond in a form satisfactory to the commissioner in an amount equal to 120 percent of the total amount of claims handled by the applicant in the prior year. If at any time the total amount of claims handled during a year exceeds the amount upon which the bond was calculated, the administrator shall immediately notify the commissioner. The commissioner may require that the bond be increased accordingly.

No contract entered into after July 1, 2001, between a licensed vendor of risk management services and a group authorized to self-insure for workers' compensation liabilities under section 79A.03, subdivision 6, may take effect until it has been filed with the commissioner, and either (1) the commissioner has approved it or (2) 60 days have elapsed and the commissioner has not disapproved it as misleading or violative of public policy.

An entity administering an insurance plan that consists of, includes, or is connected with a very high deductible health plan (VHDHP) as defined in section 62Q.01, subdivision 7, must comply with section 62Q.025, subdivision 3. This applies when the entity is either:

(i) acting under an assumption of responsibility under section 62Q.025, subdivision 3, paragraph (d); or

(ii) performing under a contract that is subject to this subdivision.

The entity must not enter into any contractual relationship or perform any services in connection with a VHDHP that does not by its terms provide for compliance with section 62Q.025, subdivision 3, either by the health plan company or by an entity administering the insurance plan under this subdivision.

(5) **Rulemaking authority.** To carry out the purposes of this subdivision, the commissioner may adopt rules pursuant to sections 14.001 to 14.69. These rules may:

(a) establish reporting requirements for administrators of insurance or self-insurance plans;

(b) establish standards and guidelines to assure the adequacy of financing, reinsuring, and administration of insurance or self-insurance plans;

(c) establish bonding requirements or other provisions assuring the financial integrity of entities administering insurance or self-insurance plans; or

(d) establish other reasonable requirements to further the purposes of this subdivision.

EFFECTIVE DATE. This section is effective August 1, 2011, and applies to very high deductible health plans offered, issued, sold, or renewed on or after that date.

Sec. 2. Minnesota Statutes 2010, section 62Q.01, is amended by adding a subdivision to read:

Subd. 7. **Very high deductible health plan or VHDHP.** "Very high deductible health plan" or "VHDHP" means a high deductible health plan that has an annual maximum out-of-pocket expense that exceeds $3,000 for individual coverage or $6,000 for family coverage.

EFFECTIVE DATE. This section is effective August 1, 2011, and applies to very high deductible health plans offered, issued, sold, or renewed on or after that date.

Sec. 3. Minnesota Statutes 2010, section 62Q.025, is amended by adding a subdivision to read:

Subd. 3. **Payment of emergency and ambulance charges.** (a) A very high deductible health plan, as defined in section 62Q.01, subdivision 7; and a health plan company that issues such a health plan, are subject to this subdivision as a condition of the privilege of issuing a VHDHP granted under subdivisions 1 and 2.

(b) A health plan company may contract with an entity administering an insurance plan, as defined in section 60A.23, subdivision 8, to assume the health plan company's duties and limitations under this subdivision. Under such a contract, the health plan company retains ultimate responsibility for compliance with this subdivision.

(c) If an enrollee in a plan described in paragraph (a) incurs charges for care provided in a hospital emergency room or for ambulance service, as defined in section 144E.001, subdivision 3, which are not payable under the plan at the time due to the enrollee not having satisfied the annual deductible, the VHDHP must require that the health plan company that issued the VHDHP pay those charges directly to the hospital or ambulance service licensee, as defined in section 144E.001, subdivision 8, within 15 days after receiving notice from the hospital or ambulance service licensee that the enrollee has not paid the charges within 30 days after the date of treatment.

(d) A health plan company that complies with paragraph (c) may seek and obtain reimbursement for those payments from its enrollee. The health plan company's collection procedures must comply with the same restrictions that would have applied to the health care provider in collecting the charges from the patient. Upon written request of the health plan company, the hospital or ambulance service licensee shall inform the health plan company in writing of any special restrictions regarding collection procedures to which the provider is subject, whether originating under contract or other agreement, law, or otherwise. No health plan company may cancel, terminate, suspend, nonrenew, or otherwise limit or reduce an enrollee's coverage, or coverage of the enrollee's family, as a means of collection or as a penalty for failure to reimburse the health plan company for a payment made under this subdivision.

EFFECTIVE DATE. This section is effective August 1, 2011, and applies to very high deductible health plans offered, issued, sold, or renewed on or after that date.