HOUSE RESEARCH

Bill Summary

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Overview

This is the omnibus insurance bill. It includes technical, clarifying, and substantive changes in the laws regulating several types of insurance.

Section

1 **Limitation on combination policies.** Technical change to add a reference to the new type of long-term care policies now permitted to be sold in Minnesota.

2 **Reduction of limits by cost of defense prohibited.** Changes a provision providing that professional liability insurance is exempt from a law prohibiting liability insurance from using legal defense costs as a reduction from the policy limit of coverage. Under current law, the exemption applies to policies with limits of liability greater than $100,000. It does not say whether the $100,000 is that amount per claim, per year, or what. This section resolves the ambiguity by making it $100,000 per year for all claims combined. Also makes the exemption provide to policies with limits of exactly $100,000, in addition to those with limits greater than that.

3 **Definitions.** Technical change to eliminate a reference to a law repealed in this bill.

4 **Loss reserve certification.** Permits the actuary certifying that a domestic property-casualty insurer's loss reserves are adequate to be an employee of that insurer. Permits the commissioner to require an independent certification, as is required under current law. Changes the wording of the certification that must be signed by the actuary. Retains the current requirement of a non-employee actuary and the current wording of the certification for "foreign" (this means out-of-state) property-casualty insurers and for life-health insurers.

5 **Fees other than examination fees.** Requires filing fees for forms and premium rates filed with the commissioner to be paid quarterly in response to an invoice. Permits electronic filing and billing.

6 **Domestic insurance corporations.** Amends the law governing mergers of insurance companies to permit reciprocal or interinsurance contract exchanges to be parties to mergers.

7 **Self-insurance or insurance plan administrators who are vendors of risk-management services.** Requires contracts between self-insured workers' compensation groups and third-party administrators (TPAs), to administer the self-insurance program, be filed with the commissioner. Requires that the contract be approved by the commissioner or be filed for 60 days without being disapproved. (This is called a "60 day deemer clause," since they are therefore deemed approved after 60 days without being disapproved.) Provides that the basis for disapproval is that the contract is "misleading or violative of public policy." For some types of self-insurance, such as health insurance, the federal Employee Retirement Income Security Act (ERISA) preempts state regulation of self-insured plans in this manner, but ERISA does not apply to workers' compensation, so this provision is not preempted.

8 **Accelerated benefits.** Defines the term "accelerated benefits" for purposes of an existing law that distinguishes between accelerated benefits and long-term care insurance. Accelerated benefits are money payments made under a life insurance policy prior to the insured's death, under certain circumstances. The definition provided in this section specifies what those certain conditions are for purposes of this law. The purpose of the existing law is to permit accelerated benefits without allowing life insurance policies with accelerated benefits to be sold as an end-run around the laws regulating long-term care insurance.

9 **Continuation of coverage.** Requires the health insurer to provide information for electing continuation coverage when requested by an employee. (Presumably this deals with situations where the employer refuses to provide the information or where the former employee does not wish to deal with the employer.)

10 **Requirement.** Same as preceding section, but applies to requests for information by spouses or dependent children who are eligible for continuation health coverage.

11 **Continuation privilege.** Same as the two preceding sections, but applies to former spouses and dependent children in divorce situations, who are eligible for continuation coverage.

12 **Coverage of dependents.** Expands the types of health coverage products to which an existing law involving dependent coverage applies. The existing law provides a minimum standard for the definition of dependent in regular health insurance and HMO contracts. This section would apply that same standard to fixed indemnity and specified disease policies, dental and vision coverage, blanket accident and sickness policies (often used to cover college students and similar groups), accident-only coverage, long-term care insurance, and Medicare-related coverage.

13 **Minimum coverage.** Provides that only the extended basic medicare supplement plan need meet all requirements of being a "qualified plan." This means the basic plan does not need to meet all of those requirements.

14 **Replacement coverage.** Corrects a cross-reference.

15 **Definitions.** Updates a definition of Medicare-related products to include the new federal Medicare+Choice program.

16 **Demonstration projects.** Permits insurance companies offering medicare supplement coverage to apply to the commissioner for approval of demonstration projects to experiment with innovative coverages. Permits the commissioner to waive any statutes or rules if necessary, except guaranteed issue. Under current law, health maintenance organizations have authority to apply for approval of demonstration projects for medicare-related coverage.

17 **Cessation of individual business.** Requires health insurers leaving the individual market and not renewing policies to give the department of commerce a list of those policyholders and

requiring the insurer to tell the policyholders about the Minnesota Comprehensive Health Association (MCHA).

18 **Major medical coverage.** Increases the lifetime maximum benefit required to meet "qualified plan" requirements from $500,000 to $1,000,000.

19 **Number three plan.** Adds a cross-reference to chapter 62Q, which is not a substantive change. Raises the lifetime maximum benefit limit to correspond to the previous section.

20 **Two small employer plans.** Makes the same change in lifetime maximum benefits for the two statutory small employer plans.

21 **Deductible-type small employer plans.** Increases requires annual deductibles for one of the statutory small employer plans.

22 **Health care services.** Adds a definition to the chapter dealing with utilization review of health care.

23 **Nonlicensed utilization review organization.** Adds a registration fee of $1,000 for initial registration and for each two-year renewal.

24 **Notification to claims administrator.** Requires prompt notice by the claims administrator to the patient and health care provider when a health claim is denied due to lack of coverage for the service.

25 **Medicare-related coverage.** Updates the definition of this term to include the new Medicare+Choice products.

26 **Right to external review.** Requires notice of right to external review for denied health claims to accompany the denial notice.

27 **Renewal; notice requirement.** Requires a notice of nonrenewal of homeowner's insurance to state the name of the insurer and the date the notice was mailed.

28 **Amendments.** Changes the procedure for amendment of plan of operation of the auto insurance high risk pool.

29 **State auto plan.** Provides auto insurance high risk pool with more flexibility on distributing applicants among insurers.

30 **State auto plan forms.** Eliminates word "standard" from description of auto insurance forms for high risk pool.

31 **Statement of reasons for cancellation or reduction.** Requires that notices of cancellation of auto insurance be mailed so as to provide 30 days notice.

32 **Notice of right to complain.** Requires notice of cancellation of auto insurance to state name of insurer and date the notice was mailed.

33 **With licensed insurers.** Permits township mutual insurers to buy reinsurance form any insurer licensed to sell the same line of insurance.

34 **Membership.** Continues the life of the worker's compensation self-insurance advisory committee.

35 **Financial standards.** Requires applicants for approval of a self-insured worker's compensation group to have 65 percent of total revenues available for claims, assessments, and stop-loss insurance purchase.

36 **If more than 100 employees; condition.** Adds language clarifying the requirement that self-insured local government health plans must be certified by the department of commerce under qualified plan requirements.

37 **Repealer.** Repeals a provision dealing with ratios of assets to liabilities and all provisions regulating prepaid legal services plans.