HOUSE RESEARCH

Bill Summary

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Overview

This is the 2004 omnibus insurance bill from the Department of Commerce. Most sections are technical.

Section

1 **Fees other than examination fees.** Eliminates a $250 filing fee for a worker's compensation "large risk alternative rating option plan" (commonly called LRARO, which is pronounced "la-rar-o"), which meets a threshold of at least $250,000 in annual premiums from a single employer. The elimination of this fee relates to section 16 of this bill.

2 **Self-insurance or insurance plan administrators who are vendors of risk management services.** This section deals with what are usually called third party administrators (TPAs). TPAs administer insured or self-insured health plans for employers. They do not bear insurance risk. Licensed insurers that also act as TPAs do not need this separate TPA license. This section changes TPA licensure from a $1,000 fee for two years to a $1,500 fee for three years.

3 **Approval of viatical settlement contract forms.** This section involves viatical settlements. A viatical settlement is the sale by a person who has life insurance of the right to collect the person's life insurance benefit when the person dies at some unknown time in the future. These sales usually involve an insured who has a chronic terminal illness, will live for an unknown period of time (often several years), does not need life insurance to provide for dependents, and wishes to have immediate cash. The purchase of a viatical settlement is an investment. These transactions are usually handled through intermediaries called viatical settlement providers or brokers, who receive a fee for their services. This section extends

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current law regulating intermediaries in viatical settlements to include brokers.

4 **Disclosure.** Makes disclosure requirements apply to viatical settlement brokers. Changes the required timing of disclosures that a viatical settlement provider or broker are required to make to the seller (called a "viator"), so that they are made when they give an application to the viator, rather than later when the viatical settlement agreement is being signed by all parties to it.

5 **Dental and vision plan coverage.** Technical clarification of a section that lists requirements that apply to health plan coverage that do not apply to dental insurance plans.

6 **Limitations on denials, conditions, and pricing of coverage.** This section deals with the "six month open window" open enrollment period for Medicare supplement insurance available after a person enrolls in Medicare Part B (Part A is hospital coverage and Part B is services of physicians and other providers). Open enrollment means the person cannot be turned down for Medicare supplement insurance for health reasons during that six-month period. Under current law, if a person who is enrolled in Medicare Part B drops that enrollment because the person has returned to work ("unretired') and has employee health coverage through the person's employer, the person gets another "six-month open window" when the person later retires again (or loses the job) and reenrolls in Medicare Part B. This section extends that to also apply to people who drop Medicare Part B because they obtain health coverage through an employer other than through becoming an employee. The typical example of this would be a person who gets that employer health coverage as a spouse or other dependent of an employee.

7 **Basic Medicare supplement plan; coverage.** Increases the required coverage for at-home recovery care from $1,600 to $4,000 per calendar year in the Medicare supplement "basic" plan.

8 **Medicare select policies and certificates.** Eliminates an annual reporting requirement on grievance procedures and experience, relating to Medicare Select coverage. Medicare Select is a Medicare supplement plan provided through a limited network of health care providers.

9 **Nonrenewal.** Insurance companies base homeowner's insurance premium rates and nonrenewal decisions partly on the insured's claims history. This section prohibits homeowner's insurance companies from including as a claim an insured's inquiry about an hypothetical or potential claim, an insured's notification of a potential claim where no claim is ultimately filed, or a claim for which the insurer does not end up paying anything.

10 **Automobile self-insurance plans.** State law permits satisfying the mandatory auto insurance requirement through self-insurance under certain conditions. Usually this is used by large employers who can establish other financial arrangements for paying claims. Changes the initial application fee for motor vehicle self-insurance from $1,500 to $2,500. Changes the renewal period from annual to three years. Changes the renewal fee for political subdivisions from $400 per year to $1,200 for three years. Changes the renewal fee for nongovernmental entities from $500 per year to $1,500 for three years.

11 **Refusal to renew.** Conforming change to prohibit insurance companies from using as claims for purposes of homeowner's nonrenewal the types of situations described in section 9 of this bill.

12 **Practices not held to be discriminatory or rebates.** Eliminates a requirement that health insurers that use a preferred provider network file certain information about it with the commissioner.

13 **Definitions.** Defines "accident and sickness insurance" for purposes of chapter 72A. The definition is identical to that used in section 62A.01. This definition is then used in the next

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section of this bill.

14 **Standards for claim filing and handling.** Uses the definition added in the previous section to clarify that a written notice requirement for claims that cannot be accepted or denied within 30 days applies to all accident and sickness insurance claims.

15 **Premium surcharge rate calculation.** Requires the commissioner to calculate a worker's compensation insurance special compensation fund surcharge rate. Describes what it must be calculated to cover. Requires that it be determined by July 1 of each year, to be effective the following January 1.

16 **Prefiling of rates.** This section involves the large risk alternative rating option (LRARO, pronounced "la-rar-o") worker's compensation premium rate plans referred to in section 1 of this bill. Changes LRARO to provide that the insurer may charge a premium rate without filing it with the commissioner if the insurer files with the commissioner a certification that the premium rate is being used only with a specified employer that generates at least $250,000 in annual worker's compensation premiums under the plan in all states combined, prior to discounts for high deductibles. Under current law, a LRARO premium rating plan must be filed with the commissioner, but is not subject to disapproval. Current law does not require the certification by the insurer.

17 **Penalties.** Makes changes to conform to the preceding section.

18 **Issuance.** Increases the initial and annual renewal licensing fee charged to data service organizations from $50 to $1,000. These are organizations of insurers that develop worker's compensation premium rates.

19 **Assessment.** Changes language involving the assessments made by the worker's compensation self-insurance security fund on employers that are individually self-insured. This security fund steps in to pay worker's compensation benefits owed to employees by a self-insured employer that becomes insolvent.

20 **Insurer payment.** Technical clarification of a law that governs the obligations of health insurers and worker's compensation insurers for injuries or illnesses that may be covered by both.

21 **Repealer.** Repeals a law requiring prior approval of advertisements by life insurance companies involving accelerated benefits and prohibiting approval if the advertisement might cause a prospective purchaser to think the product is a long-term care insurance policy. Also repeals a law requiring health plan companies to report each year statistics on the number of persons covered by that company under each of its health plans, and requiring the state and its political subdivisions s to report on its coverage of persons through the Minnesota Comprehensive Health Association (MCHA). This latter requirement was designed to monitor the practice of counties enrolling Medical Assistance enrollees in MCHA.

22 **Effective date.** Makes section 15 effective for assessments due after January 1, 2003.