HOUSE RESEARCH

Bill Summary

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Subject: Health plan company regulatory changes

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Overview

This bill makes miscellaneous changes in state regulation of health plan companies.

Section

1 **Assessment.** Eliminates a provision exempting health maintenance organizations from assessment for the insurance fraud prevention account. This account funds a Department of Commerce program that investigates fraud committed on insurance companies.

2 **Health data.** Changes the wording of a provision relating to when an HMO may release the health data of an enrollee.

3 **Annual report.** Eliminates an annual report required of health plan companies, stating how many people were covered in the preceding year by its qualified plans and by each of its unqualified plan. A "qualified plan" meets requirements found in section 62E.06.

4 **Filing requirement.** Eliminates obsolete language and a requirement for an annual filing.

5 **Disclosure of executive compensation.** Amends a law requiring health plan companies to file a list of their five highest-compensated employees. Provides for filing with the commissioner of commerce instead of with a board that has been out of existence for several years. Eliminates the option of filing a copy of the company's IRS form 990 instead.

6 **Prompt payment required.**

Subd. 1. Definitions. Amends the prompt payment law for health claims to provide that a "clean claim" includes all "coordination of benefits" information (information

Section

about other coverage that might pay the claim).

Subd. 2. Claims payments. Requires that interest payments due to health care providers from health plan companies or third-party administrators (TPAs) for late payment of claims to providers be paid without requiring the provider to send a bill for the interest.

Subd. 3. Claims filing. Requires health care providers to bill health plan companies and TPAs no later than six months after providing the service or learning the identity and address of the applicable health plan company or TPA, whichever is later. Provides that a provider who fails to comply may not collect the charge from the patient or third-party payer.

7 **Standards for claim filing and handling.** Requires health insurers to comply with the prompt payment law, and prohibits the commissioner from imposing an administrative financial penalty for failing to do so. Permits health insurers to not send an explanation of benefits (EOB) for a "zero balance EOB" (meaning the enrollee does not owe the provider anything in addition to a copayment already paid). Requires an insurer that does not send zero balance EOBs to send the enrollee a summary every six months.

8 **Federal law.** Permits insurers to release personal or privileged information about an insured or applicant without a written authorization on the same basis permitted under the federal HIPAA law for protected health information.

9 **Patient consent to release of records; liability.** Changes the wording of a provision involving when a health care provider, or a person who receives health records from a health care provider, may release health records of a patient to a third party.

10 **Duties of the commissioner of health.** Eliminates a reference to a section that was originally repealed in this bill, but that is now amended in section 0instead.

11 **Authority.** Eliminates a requirement that health insurers and other third-party payers document their compliance with the 2 percent provider tax pass-through requirement.

12 **Repealer.** Repeals (a) a law requiring reporting by self-insured employer health plans, which is preempted by the federal ERISA law; and (b) a law requiring health plan companies to maintain expanded provider networks of non-physician providers.