Overview

This bill makes changes related to health care utilization review requirements, patient protection measures, and retroactive denials of expenses, and establishes additional disclosure requirements for health plan companies and providers. It also makes a health carrier liable for health care coverage decisions if the health carrier fails to exercise ordinary care.

Section 1 deals with retroactive denials of care. Sections 2 to 4 amend provisions of the Patient Protection Act. Sections 5 to 10 amend provisions governing utilization review. Sections 12 and 16 establish additional disclosure requirements for providers and health plan companies. Sections 13 to 15 create the Health Care Liability Act.

Section

1  **Retroactive denial of expenses.** Amends § 62A.60. Prohibits a health carrier that has given preauthorization approval for a service or treatment from subsequently denying payment for that service or treatment on the ground that the service or treatment is not covered. Strikes language prohibiting a health carrier from denying payment for a service for which prior authorization was obtained, except in cases where there was fraud or substantive misrepresentation. When a health carrier communicates a decision about medical necessity to the enrollee, requires the carrier to also inform the enrollee if the service or treatment is covered.

2  **Retaliation prohibited.** Amends § 62J.71, subd.
3. Prohibits people, health plan companies, and other organizations from retaliating against health care providers on the following additional grounds:

- a provider disclosed information about the care, services, or conditions affecting an enrollee to a public regulatory agency, private accreditation body, or a management person at a health plan company;
- a provider participated in a utilization review or in an investigation by a public regulatory agency.

3 Disclosure of coverage agreement or subscriber contract. Adds subd. 1a to § 62J.72. In a section requiring health plan companies and providers to disclose certain information to enrollees, requires a health plan company to give a prospective enrollee a specimen copy of the certificate of coverage or other evidence of coverage filed with the commissioner of health or the commissioner of commerce, if the prospective enrollee so requests.

4 Retaliation. Amends § 62J.80. Prohibits a health plan company or health care provider from retaliating against a health care provider who makes a complaint, and prohibits retaliation against an enrollee, patient, or health care provider who participates in utilization review. Clarifies an existing term.

5 Notification of determinations. Amends § 62M.05, subd. 3. In paragraph (a), specifies that notice of a decision to certify for utilization review must be provided to an enrollee, in addition to the hospital and the attending physician or applicable service provider.

In paragraph (b), allows an enrollee or patient to obtain, upon request, the criteria the utilization review organization uses to determine the necessity, appropriateness, and efficacy of a health care service. A new paragraph (c) establishes the following notice procedures that a utilization review organization must follow when an initial determination is made to certify: (1) notice of the determination must be provided as soon as possible according to the case, but not later than 7 days after the date of the
Licensure requirement. Amends § 62M.09, subd. 2. In a subdivision requiring all health professionals conducting utilization reviews of health care to be licensed or certified in any U.S. jurisdiction, strikes a reference to physicians.

Physician reviewer involvement. Amends § 62M.09, subd. 3. Requires that all physicians who review cases in which a determination not to certify has been made must be licensed. Also requires, rather than permits, such physicians to be reasonably available by telephone to discuss the determination with the enrollee's attending physician.

Physician consultants. Amends § 62M.09, subd. 6. Requires, rather than permits, all physician consultants used in the appeals process for utilization reviews to be board-certified. Strikes language permitting these physician consultants to be board-certified as needed or to be board-eligible and working towards certification.

Annual report. Adds subd. 9 to § 62M.09. Requires utilization review organizations to annually report to the commissioner of commerce on the number and rate of prior authorization requests for each procedure or service that are denied, and the number and rate of these denials overturned on appeal.

Availability of criteria. Amends § 62M.10, subd. 7. Upon request, requires a utilization review organization to provide the commissioners of health and commerce with the criteria used to determine medical necessity, appropriateness, and efficacy of a procedure or service (in current law these criteria are available to enrollees and attending physicians).

Medically necessary care. Adds § 62Q.235. In a chapter governing health plan companies, defines medically necessary care as diagnostic testing and health care services that are appropriate to the enrollee's diagnosis or condition, that are...
consistent with generally accepted practice parameters, and that either help restore, establish, maintain, or improve an enrollee's health, or prevent an enrollee's health from deteriorating.

12 **Disclosure.** Amends § 62Q.58, subd. 3. Requires health plan companies to include, in member contracts or certificates of coverage, information on how to apply for a standing referral and the conditions under which a standing referral will be granted, and to provide this information to an enrollee or prospective enrollee upon request.

13 **Short title.** Adds § 62U.01. Names chapter 62U the "Health Care Liability Act."

14 **Definitions.** Adds § 62U.02. For the chapter creating liability for health carriers for certain actions, defines terms.

**Subd. 1. Enrollee.** Defines enrollee as an individual who is covered by a health carrier, health insurance, or health coverage plan.

**Subd. 2. Health plan.** Defines health plan as one of the following: a policy or certificate of accident and sickness insurance offered by a licensed insurance company; a subscriber contract or certificate offered by a nonprofit health service plan corporation; a health maintenance contract or certificate offered by an HMO; a health benefit certificate offered by a fraternal benefit society; or health coverage offered by a joint self-insurance employee health plan.

**Subd. 3. Health care provider.** Defines health care provider as a provider defined in a section governing access to health records.

**Subd. 4. Health care treatment decision.** Defines health care treatment decision as a determination or decision that affects the quality of an enrollee's diagnosis, care, or treatment, including a determination that a service is not medically necessary.

**Subd. 5. Health carrier.** Defines health carrier as a licensed insurance company offering to issue an accident and sickness insurance policy, a nonprofit health service plan corporation, an HMO, a joint self-insurance employee health plan, a CISN, a fraternal benefit society, or any organization organized to provide or administer health care services.

**Subd. 6. Medically necessary treatment.** Defines medically necessary treatment as a
service, treatment, or procedure that is appropriate for the enrollee's diagnosis or condition, that is consistent with generally accepted practice parameters, and that either helps maintain or improve the enrollee's health function, prevents deterioration of the enrollee's condition, prevents onset of a health problem, or detects a problem.

**Subd. 7. Ordinary care.** Defines ordinary care for health carriers and employees or representatives of health carriers, as the degree of care that a carrier or person in the same profession would use in the same or similar circumstances.

**Application.** Adds § 62U.03. Establishes health carrier liability for failures to exercise ordinary care, establishes defenses and limitations on defenses, specifies entities and forms of insurance not covered by this section, allows attorney's fees to be recovered, and prohibits transfers of liability.

**Subd. 1. Duty of ordinary care.** Requires a health carrier to exercise ordinary care when making health care treatment decisions. Makes a carrier liable to an enrollee for harm proximately caused by a failure to exercise ordinary care.

**Subd. 2. Responsibility for actions of others.** Makes a carrier liable to an enrollee for harm proximately caused by a health care treatment decision made by its employees, agents, or representatives.

**Subd. 3. Defenses.** Allows a health carrier to assert the following defenses in response to an action under this section:

- the carrier and its employees, agents, and representatives did not control, influence, or participate in a health care treatment decision;
- the carrier did not deny or delay payment for any service, treatment, or procedure recommended by a provider.

**Subd. 4. Limitations.** Specifies that the carrier's duty to exercise ordinary care does not mean that a carrier must provide a service, treatment, or procedure that is not covered. Also provides that an employer or employer group purchasing organization that buys coverage or is self-insured is not liable under this chapter.

**Subd. 5. Limitation on defenses.** Prohibits a health carrier from asserting as a defense that a health carrier is prohibited from practicing
Subd. 6. Nonapplication. Specifies that this chapter does not apply to workers' compensation insurance coverage or workers' compensation self-insurance.

Subd. 7. Recovery of attorney fees and other expenses. Allows a court to award attorney fees and other reasonable expenses to an enrollee if the enrollee prevails in an action under this section.

Subd. 8. Transfer of liability. Invalidates any agreement or directive that attempts to transfer liability for the health carrier's actions to a health care provider.

Disclosure of incentive agreements. Adds subd. 2a to § 144.335. In a section governing patient access to health records, requires a provider to provide a patient with a written disclosure of the precise reimbursement methodology used by the patient's health plan company to reimburse the provider. Requires the disclosure to include any provisions that create a financial incentive for the provider to limit or restrict health care provided to the patient.

Application. Specifies that the following sections do not apply to licensed insurance companies that offer, sell, or issue policies of accident and sickness insurance: section 1 (governing retroactive denials of expenses); section 2 (prohibiting retaliation against health care providers on two additional grounds); section 3 (requiring health plan companies to provide enrollees with specimen copies of certificates of coverage upon request); section 11 (defining medically necessary care); section 12 (requiring information on standing referrals to be included in health plan company member contracts or certificates of coverage); and sections 13 to 15 (establishing health carrier liability for failures to exercise ordinary care).