1.1 Senator .... moves to amend the unofficial engrossment (UEH2294-1) to
1.2 H.F. No. 2294, in conference committee, as follows:

1.3 On R1, Article 1, House language (H2294-3)

1.4 Page 2, after line 14, insert:

1.5 "Sec. 2. Minnesota Statutes 2010, section 72A.201, subdivision 8, is amended to read:

1.6 Subd. 8. **Standards for claim denial.** The following acts by an insurer, adjuster, or
1.7 self-insured, or self-insurance administrator constitute unfair settlement practices:

1.8 (1) denying a claim or any element of a claim on the grounds of a specific policy
1.9 provision, condition, or exclusion, without informing the insured of the policy provision,
1.10 condition, or exclusion on which the denial is based;

1.11 (2) denying a claim without having made a reasonable investigation of the claim;

1.12 (3) denying a liability claim because the insured has requested that the claim be
1.13 denied;

1.14 (4) denying a liability claim because the insured has failed or refused to report the
1.15 claim, unless an independent evaluation of available information indicates there is no
1.16 liability;

1.17 (5) denying a claim without including the following information:

1.18 (i) the basis for the denial;

1.19 (ii) the name, address, and telephone number of the insurer's claim service office
1.20 or the claim representative of the insurer to whom the insured or claimant may take any
1.21 questions or complaints about the denial;

1.22 (iii) the claim number and the policy number of the insured; and

1.23 (iv) if the denied claim is a fire claim, the insured's right to file with the Department
1.24 of Commerce a complaint regarding the denial, and the address and telephone number
1.25 of the Department of Commerce;

1.26 (6) denying a claim because the insured or claimant failed to exhibit the damaged
1.27 property unless:

1.28 (i) the insurer, within a reasonable time period, made a written demand upon the
1.29 insured or claimant to exhibit the property; and

1.30 (ii) the demand was reasonable under the circumstances in which it was made;

1.31 (7) denying a claim by an insured or claimant based on the evaluation of a chemical
1.32 dependency claim reviewer selected by the insurer unless the reviewer meets the
1.33 qualifications specified under subdivision 8a. An insurer that selects chemical dependency
1.34 reviewers to conduct claim evaluations must annually file with the commissioner of
1.35 commerce a report containing the specific evaluation standards and criteria used in these
1.36 evaluations. The report must be filed at the same time its annual statement is submitted

2.1 under section 60A.13. ~~The report must also include the number of evaluations performed~~
2.2 ~~on behalf of the insurer during the reporting period, the types of evaluations performed,~~
2.3 ~~the results, the number of appeals of denials based on these evaluations, the results of~~
2.4 ~~these appeals, and the number of complaints filed in a court of competent jurisdiction.~~

2.5 **EFFECTIVE DATE.** This section is effective the day following final enactment."
2.6 On R16, Article 1, Senate language, (UEH2294-1)
2.7 Page 9, delete section 5 and insert:

2.8 "Sec. 6. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision
2.9 to read:
2.10 Subd. 9d. **Financial audit.** (a) The legislative auditor shall contract with an audit
2.11 firm to conduct a biennial independent third-party financial audit of the information
2.12 required to be provided by managed care plans and county-based purchasing plans
2.13 under subdivision 9c, paragraph (b). The audit shall be conducted in accordance
2.14 with generally accepted government auditing standards issued by the United States
2.15 Government Accountability Office. The contract with the audit firm shall be designed
2.16 and administered so as to render the independent third-party audit eligible for a federal
2.17 subsidy, if available. The contract shall require the audit to include a determination of
2.18 compliance with the federal Medicaid rate certification process. The contract shall require
2.19 the audit to determine if the administrative expenses and investment income reported
2.20 by the managed care plans and county-based purchasing plans are reasonable and are
2.21 properly and fairly allocated across the plans' commercial and state health care programs
2.22 and across individual state health care programs.
2.23 (b) For purposes of this subdivision, "independent third-party" means an audit firm
2.24 that is independent in accordance with government auditing standards issued by the United
2.25 States Government Accountability Office and licensed in accordance with chapter 326A.
2.26 An audit firm under contract to provide services in accordance with this subdivision must
2.27 not have provided services to a managed care plan or county-based purchasing plan during
2.28 the three years prior to or during the period in which the audit is conducted.
2.29 (c) The commissioner shall require in the request for bids and resulting contracts
2.30 with managed care plans and county-based purchasing plans under this section and section
2.31 256B.692, that each managed care plan and county-based purchasing plan submit to and
2.32 fully cooperate with an annual independent third-party financial audit of the information
2.33 required under subdivision 9c, paragraph (b). Each contract with a managed care plan or
2.34 county-based purchasing plan under this section or section 256B.692, must provide the
2.35 commissioner, the legislative auditor, and the audit firm contracting with the legislative

3.1 auditor unlimited access to any and all data required to complete the audit and that this
3.2 access shall be enforceable in a court of competent jurisdiction through injunctive or other
3.3 appropriate relief. The contracting audit firm shall be deemed a designee of the legislative
3.4 auditor with the same powers as the legislative auditor under section 3.978, subdivision 2.

3.5 (d) Each managed care plan and county-based purchasing plan shall provide to the
3.6 commissioner bi-weekly encounter data and claims data at a detailed level and shall
3.7 participate in a quality assurance program that verifies the timeliness, completeness,
3.8 accuracy, and consistency of the data provided. The commissioner shall develop written
3.9 protocols for the quality assurance program and shall make the protocols publicly
3.10 available. The commissioner shall contract for an independent third-party audit to evaluate
3.11 the quality assurance protocols as to the capacity of the protocols to ensure complete
3.12 and accurate data and to evaluate the commissioner's implementation of the protocols.
3.13 The audit firm under contract to provide this evaluation must meet the requirements in
3.14 paragraph (b).

3.15 (e) Upon completion of the audit under paragraph (a) and its receipt by the
3.16 legislative auditor, the legislative auditor shall provide copies of the audit report to the
3.17 commissioner, the state auditor, the attorney general, and the chairs and ranking minority
3.18 members of the health finance committees of the legislature. Upon completion of the
3.19 audit under paragraph (d), the commissioner shall provide copies of the audit report to
3.20 the legislative auditor and the chairs and ranking minority members of the health finance
3.21 committees of the legislature.

3.22 (f) Any actuary or actuarial firm under contract with the commissioner to provide
3.23 actuarial services must meet the independence requirements under the professional code
3.24 for fellows in the Society of Actuaries and must not have provided actuarial services to
3.25 a managed care plan or county-based purchasing plan that is under contract with the
3.26 commissioner pursuant to this section and section 256B.692 during the three years prior
3.27 to or during the period in which the actuarial services are being provided. An actuary or
3.28 actuarial firm meeting the requirements of this paragraph must certify and attest to the
3.29 rates paid to the managed care plans and county-based purchasing plans under this section
3.30 and section 256B.692, and the certification and attestation must be auditable.

3.31 **EFFECTIVE DATE.** This section is effective the day following final enactment
3.32 and applies to the managed care and county-based purchasing plan contracts that are
3.33 effective January 1, 2014, and biennially thereafter."

3.34 On R30, Article 1, House language (H2294-3)

3.35 Page 26, after line 5, insert:

4.1 "Sec. 33. **REPORTING REQUIREMENTS.**

4.2 Subdivision 1. **Evidence-based childbirth program.** The commissioner of human
4.3 services may discontinue the evidence-based childbirth program and shall discontinue all
4.4 affiliated reporting requirements established under Minnesota Statutes, section 256B.0625,
4.5 subdivision 3g, once the commissioner determines that hospitals representing at least 90
4.6 percent of births covered by Medical Assistance or MinnesotaCare have approved policies
4.7 and processes in place that prohibit elective inductions prior to 39 weeks' gestation.

4.8 Subd. 2. **Provider networks.** The commissioner of health, the commissioner of
4.9 commerce, and the commissioner of human services shall merge reporting requirements
4.10 for health maintenance organizations and county-based purchasing plans related to
4.11 Minnesota Department of Health oversight of network adequacy under Minnesota
4.12 Statutes, section 62D.124, and the provider network list reported to the Department of
4.13 Human Services under Minnesota Rules, part 4685.2100. The commissioners shall work
4.14 with health maintenance organizations and county-based purchasing plans to ensure that
4.15 the report merger is done in a manner that simplifies health maintenance organization and
4.16 county-based purchasing plan reporting processes.

4.17 **EFFECTIVE DATE.** This section is effective the day following final enactment.

4.18 Sec. 34. **REPEALER.**

4.19 Subdivision 1. **Summary of complaints and grievances.** (a) Minnesota Rules, part
4.20 4685.2000, is repealed effective the day following final enactment.

4.21 Subd. 2. **Medical necessity denials and appeals.** Minnesota Statutes 2010, section
4.22 62M.09, subdivision 9, is repealed effective the day following final enactment.

4.23 Subd. 3. **Salary reports.** Minnesota Statutes 2010, section 62Q.64, is repealed
4.24 effective the day following final enactment."

4.25 Renumber the sections in sequence and correct the internal references