HOUSE RESEARCH

Bill Summary

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Overview

This bill sets requirements for contracting between health plan companies and health care providers, modifies prior authorization procedures, and expands the scope of an existing provision regulating shadow contracting.

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1 **Prior authorization of services.** Amends § 62M.07. Requires utilization review organizations, health plan companies, or claim administrators to provide a system for prompt provider access by telephone, facsimile, voice mail, or through an electronic mechanism, 24 hours a day and seven days a week, if prior authorization is required. This provision does not apply to dental services covered under MinnesotaCare, medical assistance, and general assistance medical care.

2 **Citation.** Adds § 62Q.732. Provides that §§ 62Q.732 to 62Q.752 may be cited as the "Minnesota Health Plan Contracting Act."

3 **Definitions.** Adds § 62Q.733. Defines the following terms: contract, health care provider or provider, health plan company, and fee schedule. The definition of provider includes most health care providers, other than hospitals, ambulatory surgery centers, and free-standing emergency rooms. These definitions apply only to sections 2 to 8 of this bill.

4 **Exemption.** Adds § 62Q.734. Exempts health plan companies with annual Minnesota health premium revenues that are less than 3 percent of total Minnesota premium revenues from the following sections: 62Q.735 to 62Q.739, 62Q.74, and 62Q.752.

5 **Provider contracting procedures.** Adds § 62Q.735. Specifies disclosure requirements for provider contracts and amendments.

Subd. 1. Contract disclosure. Requires health plan companies, before requiring a

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provider to sign an initial contract, to: give or make available to the provider a complete copy of the proposed contract, including specified items; and make available to the provider a method or process that allows the provider to determine total expected payment amounts for each health care service. Contains special provisions regarding dental fee schedules.

Subd. 2. Proposed amendments. Requires amendments or changes in contract terms to be disclosed to the provider at least 90 days before their effective date, with the exception of amendments required by law or governmental regulatory authority. Also requires providers to be given the opportunity to terminate a contract before an amendment or change becomes effective, if the amendment or change alters financial reimbursement or policies or procedures governing the provider and health plan company relationship. Allows the parties to waive these disclosure requirements by mutual consent.

Subd. 3. Hospital contract amendment disclosure. Requires that changes in contracts between "network organizations" (defined in paragraph (c)) and hospitals, ambulatory surgical centers, and freestanding emergency rooms be disclosed to the provider. Requires that certain types of changes do not go into effect until disclosed to the provider.

6 **Payment rates.** Adds § 62Q.736. Requires a contract between a health plan company and a provider to comply with § 62A.64 (health insurance and prohibited agreements).

7 **Service code changes.** Adds § 62Q.737. Prohibits a health plan company from changing a service code properly submitted by a health care provider. Establishes a procedure for health plan companies to correct errors in submitted claims.

8 **Unilateral terms prohibited.** Adds § 62Q.739. Prohibits contracts from containing or requiring unilateral terms regarding indemnification or arbitration but allows a contract to be unilaterally terminated by either party in accordance with contract terms. Prohibits a health plan company from terminating or failing to renew a provider contract unless the provider has been given a written notice specifying the reason 120 days before the effective date.

9 **Network shadow contracting.** Amends § 62Q.74. Expands the scope of the prohibition on "shadow contracting" by expanding the definition of provider and including all health plan companies. The expanded definition of provider adds hospitals and similar entities. Also prohibits a health plan company from requiring a provider to participate in a new or different plan, product, or arrangement within a category of coverage that results in a different "underlying financial reimbursement methodology", without provider consent. Provides an exception for government programs. Makes various conforming changes.

In subdivision 6, provides that the term "underlying financial reimbursement methodology" does not apply to "benefit design" features, such as co-payments or other payments required of enrollees.

10 **Claims payments.** Amends § 62Q.75, subd. 2. If a claim is determined not to be "clean," requires providers to be informed of the reasons for the determination within 30 days of receipt, except that specific reasons need not be given if there is evidence of suspected fraud. Prohibits a health plan company or third party administrator from requiring a provider to bill for interest payments on claims that are paid late, and requires interest to be paid at least quarterly. Allows the commissioner to assess a financial penalty when there is a pattern of

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abuse. Uses the expanded definitions of "provider" and "health plan company" provided in section 9.

11 **Repealer.** Repeals § 62Q.745 (provider contract amendment disclosure). This existing law becomes redundant with the enactment of section 5 of this bill.

12 **Effective date.** Makes sections 1, 2, and 4 effective for provider contracts issued, renewed, or amended on or after July 1, 2004. Makes sections 3, 6, 8, and 10 effective for provider contracts issued, renewed, or amended on or after January 1, 2005. Makes sections 5, 7, 9, and 11 effective for provider contracts issued, renewed, or amended on or after July 1, 2006.