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 liability for prior authorization decisions, and expands the scope of an existing provision regulating shadow contracting.

Section

1 **Prior notification or authorization of services.** Amends § 62M.07. Requires utilization review organizations, health plan companies, or claim administrators to provide a system for prompt provider access through voice mail or e-mail, Web site, or Internet communications, 24 hours a day and seven days a week, if prior notification or prior authorization is required. Prohibits charging providers a fee for submitting prior notification information or requesting prior authorization. Classifies decisions not to authorize a service as a medical decision and specifies the entity not authorizing the service is subject to civil liability in the same manner as a health care provider.

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

3 **Definitions.** Adds § 62Q.733. Defines the following terms: contract, health care provider or provider, health plan company, and total expected payment.

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.737, 62Q.739, 62Q.74, 62Q.75, subd. 1, and 62Q.751.

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 provider to sign a contract, to: give the provider a complete copy of the proposed contract, including specified items; make available to the provider a method or process that allows the provider to determine total expected payment amounts for each health care service; make available to the provider upon request the specific total expected payment amounts for each service; and allow the provider 90 days to sign the contract.

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.

6 **Payment rates.** Adds § 62Q.736. Prohibits a provider from being required by a health plan company, by contract, policy or otherwise, to accept payment amounts agreed to in contract with another health plan company or amounts other than those stated in the contract with the health plan company.

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 **Recoupments.** Adds § 62Q.738. Requires health plan companies to give providers written notices explaining any recoupment and gives providers 30 days to appeal a proposed recoupment or pay the invoice. Prohibits a health plan company from recouping amounts exceeding $100 before expiration of the 30-day period or completion of the appeal process, unless the provider consents. Sets procedures for payment of recoupments found to be appropriate upon appeal. Limits attempts to recoup payments to the lesser of six months after claim payment or the period of time required in the contract for the submission of initial claims, except in the case of fraud or intentional misrepresentation.

9 **Unilateral terms prohibited.** Adds § 62Q.739. Prohibits contracts from containing or requiring unilateral terms regarding termination, indemnification, or arbitration. 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, unless termination or nonrenewal is deemed necessary to protect the public health.

10 **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. Also extends the scope of the prohibition to include all new or existing health plans, products, or other arrangements within a category of coverage, unless provider consent is obtained. (Current law provides an exception for plans or arrangements within an existing category of coverage.) Makes various conforming changes.

11 **Submitting claims.** Amends § 62Q.75, by adding subd. 1a. Requires providers to submit initial claims within a reasonable period as provided in contract or within one year, and any final claims within 15 months of the date of service.

12 **Claims payments.** Amends § 62Q.75, subd. 2. Requires clean claims to be paid within 30 days after the date the provider submitted the claim (current law refers to the date the claim is received). If a claim is determined not to be clean or eligible, requires providers to be informed of the determination and reasons preventing timely payment, within 30 days of submittal. 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 automatically with the original claim. Requires providers to be informed promptly if a

claim is delayed and of the reasons for the delay.

13 **Utilization profiling.** Adds § 62Q.751. Sets requirements for the use of utilization profiling by health plan companies and health plan sponsors.

Subd. 1. Disclosure. Requires health plan companies or health plan sponsors that use data for utilization profiling to make information on the methodology and other factors affecting a provider's profile available to providers and their agents at least 90 days before release.

Subd. 2. Release of data; appeal. Requires health plan companies or health plan sponsors to give providers the opportunity to provide relevant information, requires the information to be considered, and requires a written response before data release. Also requires an appeal process.

14 **Total expected payment disclosure.** Adds § 62Q.752. Requires a health plan company to make available to persons bearing financial risk for the provision of health services the total expected payment for health services. Allows persons having a choice of providers to receive the total expected payment information applicable to multiple providers.

15 **Repealer.** Repeals § 62Q.745 (provider contract amendment disclosure).