SENATE
STATE OF MINNESOTA
NINETY-FOURTH SESSION

S.F. No. 1107

(SENATE AUTHORS: GRUENHAGEN)

DATE	D-PG	OFFICIAL STATUS
02/06/2025		Introduction and first reading
		Referred to Health and Human Services

A bill for an act

relating to health care; requiring disclosure of certain health care provider reimbursement arrangements to enrollees and health care providers; modifying the duties of the ombudsperson for public managed health care programs; providing health carrier liability when a health care provider is limited in providing services by the health carrier; amending Minnesota Statutes 2024, sections 62J.72, subdivision 1; 62Q.735, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 604.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2024, section 62J.72, subdivision 1, is amended to read:

Subdivision 1. **Written disclosure.** (a) A health plan company, as defined under section 62J.70, subdivision 3~~,~~; a health care network cooperative, as defined under section 62R.04, subdivision 3~~, and~~; a health care provider, as defined under section 62J.70, subdivision 2~~,~~; and all payers that use value-based payment shall, during open enrollment, upon enrollment, and annually thereafter, provide enrollees with a description of the ~~general nature of the~~ reimbursement methodologies used by the health plan company, health insurer, or health coverage plan to pay providers. The description must explain clearly any aspect of the reimbursement methodology that creates a financial incentive for the health care provider to limit or restrict the health care provided to enrollees~~.~~, including any aspect of a reimbursement methodology in which:

(1) payments to health care providers are based on the volume of care provided or the number of referrals to or utilization of specialists;

(2) providers provide services to a specified patient population for an agreed-upon total cost of care or are reimbursed under a risk/gain sharing payment arrangement; or

(3) provider reimbursement is based on provider tiering, with providers assigned to tiers based on the cost of care provided, the volume of care provided, or the number of referrals to or utilization of specialists.

The description must also clearly explain how the reimbursement methodology operates to limit or restrict, or may have the effect of limiting or restricting, the health care provided to enrollees and the specific limitations or restrictions of health care that enrollees may experience. An entity required to disclose shall also disclose if no reimbursement methodology is used that creates a financial incentive for the health care provider to limit or restrict the health care provided to enrollees. This description may be incorporated into the member handbook, subscriber contract, certificate of coverage, or other written enrollee communication. The ~~general~~ reimbursement methodology shall be made available to employers at the time of open enrollment.

(b) Health plan companies, health care network cooperatives, and providers must, upon request, provide an enrollee with specific information regarding the reimbursement methodology, including, but not limited to, the following information:

(1) a concise written description of the provider payment plan, including any incentive plan applicable to the enrollee;

(2) a written description of any incentive to the provider relating to the provision of health care services to enrollees, including any compensation arrangement that is dependent on the amount of health coverage or health care services provided to the enrollee, or the number of referrals to or utilization of specialists; and

(3) a written description of any incentive plan that involves the transfer of financial risk to the health care provider.

(c) The disclosure statement under paragraph (a) describing the ~~general nature of the~~ reimbursement methodologies must comply with the Readability of Insurance Policies Act in chapter 72C and must be filed with and approved by the commissioner prior to its use.

(d) A disclosure statement that has been filed with the commissioner for approval under paragraph (c) is deemed approved 30 days after the date of filing, unless approved or disapproved by the commissioner on or before the end of that 30-day period.

(e) The disclosure statement under paragraph (a) describing the ~~general nature of the~~ reimbursement methodologies must be provided upon request in English, Spanish, Vietnamese, and Hmong. In addition, reasonable efforts must be made to provide information contained in the disclosure statement to other non-English-speaking enrollees.

(f) ~~Health plan companies and providers may enter into agreements to determine how to respond to enrollee requests received by either the provider or the health plan company. This subdivision does not require disclosure of specific amounts paid to a provider, provider fee schedules, provider salaries, or other proprietary information of a specific health plan company or health insurer or health coverage plan or provider.~~ The disclosures required by the subdivision are deemed to not constitute disclosures of proprietary or trade secret information.

EFFECTIVE DATE. This section is effective January 1, 2025.

Sec. 2. Minnesota Statutes 2024, section 62Q.735, subdivision 1, is amended to read:

Subdivision 1. **Contract disclosure.** (a) Before requiring a health care provider to sign a contract, a health plan company shall give to the provider a complete copy of the proposed contract, including:

(1) all attachments and exhibits;

(2) operating manuals;

(3) a general description of the health plan company's health service coding guidelines and requirement for procedures and diagnoses with modifiers, and multiple procedures; and

(4) all guidelines and treatment parameters incorporated or referenced in the contract.

(b) The health plan company shall make available to the provider:

(1) the fee schedule or a method or process that allows the provider to determine the fee schedule for each health care service to be provided under the contract~~.~~; and

(2) a description of any conditions in the contract that are related to provider reimbursement and that may have the effect of limiting or restricting the health care services the provider provides to enrollees.

(c) Nothing in this section requires a dental plan organization to disclose the plan's aggregate maximum allowable fee table used to determine other providers' fees. The contracted provider must not release this information in any way that would violate any state or federal antitrust law.

(d) The disclosures required by this subdivision are deemed to not constitute disclosures of proprietary or trade secret information.

EFFECTIVE DATE. This section is effective January 1, 2025.

Sec. 3. **[604.112] HEALTH CARRIER LIABILITY.**

Subdivision 1. **Definition.** For purposes of this section, "health carrier" has the meaning given in section 62A.011, subdivision 2.

Subd. 2. **Liability.** If a health carrier agrees to compensate a health care provider for the provision of services to a patient and the amount of the compensation is conditioned by a limit on the amount of services to be provided by the provider, then the health carrier is liable for an injury to a patient caused in whole or in part by a delay or denial of care if the delay or denial of care was a consequence of the limit.

Subd. 3. **Information on reimbursement methodology.** Disclosure in an action brought under this section of information on the reimbursement methodology used by a health carrier to compensate a health care provider is deemed to not constitute the disclosure of proprietary or trade secret information.

EFFECTIVE DATE. This section is effective for causes of action accruing on or after August 1, 2025.