

1.1 A bill for an act

1.2 relating to health; regulating participating provider agreements between health
1.3 plan companies and health care providers; amending Minnesota Statutes 2008,
1.4 sections 62Q.735, by adding subdivisions; 62Q.75, subdivision 3, by adding a
1.5 subdivision; proposing coding for new law in Minnesota Statutes, chapter 62Q.

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

1.7 Section 1. Minnesota Statutes 2008, section 62Q.735, is amended by adding a
1.8 subdivision to read:

1.9 Subd. 4. **Contract amendment and renewal provisions.** (a) A health plan
1.10 company shall not require a provider to provide notice of intention to terminate its contract
1.11 before communicating with the provider regarding contract renewals. A health plan
1.12 company shall not communicate with enrollees about the possible termination until final
1.13 termination notice is received from the provider.

1.14 (b) A health plan company shall not preclude a nonnetwork provider from
1.15 subsequent network participation solely as a result of the provider having terminated its
1.16 participation in accordance with the terms of its contract.

1.17 **EFFECTIVE DATE.** This section is effective January 1, 2011, and applies to
1.18 contracts entered into, renewed, or amended on or after that date.

1.19 Sec. 2. Minnesota Statutes 2008, section 62Q.735, is amended by adding a subdivision
1.20 to read:

1.21 Subd. 5. **Fee schedules.** (a) A health plan company shall provide, upon request,
1.22 any additional fees or fee schedules relevant to the particular provider's practice beyond
1.23 those provided with the renewal documents for the next contract year to all participating

2.1 providers, excluding claims paid under the pharmacy benefit. Health plan companies may
2.2 fulfill the requirements of this section by making the full fee schedules available through a
2.3 secure Web portal for contracted providers.

2.4 (b) A dental organization may satisfy paragraph (a) by complying with section
2.5 62Q.735, subdivision 1, paragraph (c).

2.6 **EFFECTIVE DATE.** This section is effective January 1, 2011, and applies to
2.7 contracts entered into, renewed, or amended on or after that date.

2.8 Sec. 3. Minnesota Statutes 2008, section 62Q.735, is amended by adding a subdivision
2.9 to read:

2.10 Subd. 6. **Reimbursement tiering methodologies.** Where health plan company
2.11 reimbursement is related to tiering of providers, the health plan company shall provide to
2.12 any tiered providers upon request an explanation of the methodology used to calculate tier
2.13 ranking, including information on cost and quality. This explanation need not allow any
2.14 provider access to proprietary or trade secret information. When a tiered product is used
2.15 by a health plan, the health plan company shall provide notification to the provider of the
2.16 tier in which the provider is included prior to the effective date of the tiered product.

2.17 **EFFECTIVE DATE.** This section is effective January 1, 2011, and applies to
2.18 contracts entered into, renewed, or amended on or after that date.

2.19 Sec. 4. Minnesota Statutes 2008, section 62Q.75, subdivision 3, is amended to read:

2.20 Subd. 3. **Claims filing.** Unless otherwise provided by contract, by section 16A.124,
2.21 subdivision 4a, or by federal law, the health care providers and facilities specified
2.22 in subdivision 2 must submit their charges to a health plan company or third-party
2.23 administrator within six months from the date of service or the date the health care
2.24 provider knew or was informed of the correct name and address of the responsible health
2.25 plan company or third-party administrator, whichever is later. A health care provider or
2.26 facility that does not make an initial submission of charges within the six-month period
2.27 shall not be reimbursed for the charge and may not collect the charge from the recipient of
2.28 the service or any other payer. The six-month submission requirement may be extended to
2.29 12 months in cases where a health care provider or facility specified in subdivision 2 has
2.30 determined and can substantiate that it has experienced a significant disruption to normal
2.31 operations that materially affects the ability to conduct business in a normal manner and to
2.32 submit claims on a timely basis. Any request by a health care provider or facility specified
2.33 in subdivision 2 for an exception to a contractually defined claims submission timeline

3.1 must be reviewed and acted upon by the health plan company within the same time frame
3.2 as the contractually agreed upon claims filing timeline. This subdivision also applies to all
3.3 health care providers and facilities that submit charges to workers' compensation payers
3.4 for treatment of a workers' compensation injury compensable under chapter 176, or to
3.5 reparation obligors for treatment of an injury compensable under chapter 65B.

3.6 **EFFECTIVE DATE.** This section is effective January 1, 2011, and applies to
3.7 contracts entered into, renewed, or amended on or after that date.

3.8 Sec. 5. Minnesota Statutes 2008, section 62Q.75, is amended by adding a subdivision
3.9 to read:

3.10 Subd. 4. **Claims adjustment timeline.** (a) Once a clean claim, as defined in section
3.11 62Q.75, subdivision 1, has been paid, the contract must provide a 12-month deadline on
3.12 all adjustments to and recouments of the payment with the exception of payments related
3.13 to coordination of benefits, subrogation, duplicate claims, retroactive terminations, and
3.14 cases of fraud and abuse.

3.15 (b) Paragraph (a) shall not apply to pharmacy contracts entered into between or on
3.16 behalf of health plan companies.

3.17 **EFFECTIVE DATE.** This section is effective January 1, 2011, and applies to
3.18 contracts entered into, renewed, or amended on or after that date.

3.19 Sec. 6. **[62Q.751] COLLECTING DEDUCTIBLES AND COINSURANCE.**

3.20 A health plan company shall not prohibit providers from collecting deductibles and
3.21 coinsurance from patients at or prior to the time of service. Providers may not withhold a
3.22 service to a health plan company enrollee based on a patient's failure to pay a deductible
3.23 or coinsurance at or prior to the time of service. Overpayments by patients to providers
3.24 must be returned to the patient by the provider by check or electronic payment within 30
3.25 days of the date in which the claim adjudication is received by the provider.