62Q.74 NETWORK SHADOW CONTRACTING.

Subdivision 1. **Definitions.** (a) For purposes of this section, "category of coverage" means one of the following types of health-related coverage:

(1) health;

(2) no-fault automobile medical benefits; or

(3) workers' compensation medical benefits.

(b) "Health care provider" or "provider" means a physician, chiropractor, dentist, podiatrist, hospital, ambulatory surgical center, freestanding emergency room, or other provider, as defined in section 62J.03.

Subd. 2. **Provider consent required.** (a) No health plan company shall require a health care provider to participate in a network under a category of coverage that differs from the category or categories of coverage to which the existing contract between the health plan company and the provider applies, without the affirmative consent of the provider obtained under subdivision 3.

(b) No health plan company shall require, as a condition of participation in any health plan, product, or other arrangement, the provider to participate in a new or different health plan, product, or other arrangement within a category of coverage that results in a different underlying financial reimbursement methodology without the affirmative consent of the provider obtained under subdivision 3. This paragraph does not apply to participation in health plan products or other arrangements that provide health care services to government programs, including state public programs, Medicare, and Medicare-related coverage.

(c) Compliance with this section may not be waived in a contract or otherwise.

Subd. 3. **Consent procedure.** (a) The health plan company, if it wishes to apply an existing contract with a provider to a different category of coverage or health plan, product, or other arrangement within a category of coverage that results in a different underlying financial reimbursement methodology, shall first notify the provider in writing. The written notice must include at least the following:

(1) the health plan company's name, address, and telephone number, and the name of the specific network, if it differs from that of the health plan company;

(2) a description of the proposed new category of coverage or health plan, product, or other arrangement within a category of coverage;

(3) the names of all payers expected by the health plan company to use the network for the new category of coverage or health plan, product, or other arrangement within a category of coverage;

(4) the approximate number of current enrollees of the health plan company in that category of coverage or health plan, product, or other arrangement within a category of coverage within the provider's geographical area;

(5) a disclosure of all contract terms of the proposed new category of coverage or health plan, product, or other arrangement within a category of coverage, including the discount or reduced fees, care guidelines, utilization review criteria, prior notification process, prior authorization process, and dispute resolution process;

(6) a form for the provider's convenience in accepting or declining participation in the proposed new category of coverage or health plan, product, or other arrangement within a category of coverage, provided that the provider need not use that form in responding; and

(7) a statement informing the provider of the provisions of paragraph (b).

(b) Unless the provider has affirmatively agreed to participate within 60 days after the postmark date of the notice, the provider is deemed to have not accepted the proposed new category of coverage or health plan, product, or other arrangement within a category of coverage that results in a different underlying financial reimbursement methodology.

Subd. 4. **Contract termination restricted.** A health plan company must not terminate an existing contract with a provider, or fail to honor the contract in good faith, based solely on the provider's decision not to accept a proposed new category of coverage or health plan, product, or other arrangement within a category of coverage that results in a different underlying financial reimbursement methodology. The most recent agreed-upon contractual obligations remain in force until the existing contract's renewal or termination date.

Subd. 5. **Remedy.** If a health plan company violates this section by reimbursing a provider as if the provider had agreed under this section to participate in the network under a category of coverage or health plan, product, or other arrangement within a category of coverage that results in a different underlying financial reimbursement methodology to which the provider has not agreed, the provider has a cause of action against the health plan company to recover two times the difference between the reasonable charges for claims affected by the violation and the amounts actually paid to the provider. The provider is also entitled to recover costs, disbursements, and reasonable attorney fees.

Subd. 6. **Benefit design changes.** For purposes of this section, "different underlying financial reimbursement methodology" does not include health plan benefit design changes, including, but not limited to, changes in co-payment or deductible amounts or other changes in member cost-sharing requirements.

History: *1999 c 94 s 1; 2000 c 322 s 1; 2001 c 170 s 4,5; 2004 c 246 s 9*