

# Transparency in Risk-Sharing Contracts

Under Minnesota statutory law, reimbursement methodologies that create a financial incentive to limit or restrict health care for patients must be disclosed. The following is a summary of those state requirements.

Under Minnesota Statute 62J.72, health plan companies (including health carriers and community integrated service networks), health care network cooperatives (including corporations organized and licensed under chapter 62R of the Minnesota statutes and generally have fewer than 50,000 enrollees), and health care providers (including physicians, nurses, hospitals individuals or entities that provide health care services under the medical assistance, general assistance medical care, MinnesotaCare, or state employee group insurance program, as well as an association, partnership, corporation, limited liability corporation, or other organization organized for the purposes of providing, arranging, or administering health care services or treatment) are required to provide enrollees with a general description of the reimbursement methodologies used by the health plan company, health insurer, or health coverage plan to pay providers<sup>1</sup>.

The description must:

- Be provided during open enrollment, upon enrollment, and annually thereafter;
- It must explain any aspect of the reimbursement methodology that creates (or does not create) a financial incentive for the health care provider to limit or restrict the health care provided to enrollees;
- Be easy to read and comply with the Readability of Insurance Policies Act in Chapter 72C (<https://www.revisor.leg.state.mn.us/statutes/?id=72C.06>);
- Be filed with and approved by the commissioner of health prior to its use;<sup>2</sup> and
- Be provided upon request in English, Spanish, Vietnamese, and Hmong. Reasonable efforts must be made to provide information contained in the disclosure to other non-English-speaking enrollees, as well.

This general description may be incorporated into the member handbook, subscriber contract, certificate of coverage, or other written enrollee communication. If the written disclosure makes a comparison of the financial incentives between the providers with whom it contracts, then it must describe the incentives that occur at the provider level.

Upon request, health plan companies, health care network cooperatives, and providers must provide the enrollee with more specific information regarding the reimbursement methodology, including the following:

- A concise written description of the provider payment plan, including any incentive plan applicable to the enrollee;
- A written description of any incentive offered 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
- A written description of any incentive plan that involves the transfer of financial risk to the health care provider.

Health plan companies and providers may enter into agreements on how to respond to enrollee requests received by the provider or the health plan company.

<sup>1</sup> Note: 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 is not required. Furthermore, physicians and nurses are not required to individually provide information required under this statute if it has been provided by another individual or entity that is also subject to the statute.

<sup>2</sup> A disclosure statement that has been filed with the commissioner for approval 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.

