S.F. No. 3480 and H.F. No. 3893, which had been referred to the Chief Clerk for comparison, were examined and found to be not identical.

The following document shows the differences between S.F. No. 3480, the third engrossment, and H.F. No. 3893, the first engrossment.

Patrick D. Murphy
May 2, 2018 Chief Clerk, House of Representatives

Explanation of Comparison Reports

When a Senate File is received from the Senate, it is given its first reading and must be referred to the appropriate standing committee or division under Rule 1.11.

But if the House File companion of that Senate File has already been reported out of Committee and given its second reading and is on the General Register, the Senate File must be referred to the Chief Clerk for comparison pursuant to Rule 1.15.

The Chief Clerk reports whether the bills were found to be identical or not identical. Once the bills have been compared and the differences have been reported, the Senate File is given its second reading and is substituted for the House File. The House File is then considered withdrawn.

Pursuant to rule 3.33, if the bills are not identical and the chief author of the bill wishes to use the House language, the chief author must give notice of their intent to substitute the House language when the bill is placed on the Calendar for the Day or the Fiscal Calendar. If the chief author of the bill wishes to keep the Senate language, no action is required.

H3893-1

A bill for an act

relating to health care; adding provisions to the price disclosure requirements for providers and health plan companies; requiring a provider to maintain a list of services and the provider's charge for each service; amending Minnesota Statutes 2016, section 62J.81; proposing coding for new law in Minnesota Statutes, chapter 62J.

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

Section 1. Minnesota Statutes 2016, section 62J.81, is amended to read:

62J.81 DISCLOSURE OF PAYMENTS FOR HEALTH CARE SERVICES.

Subdivision 1. **Required disclosure ~~of estimated payment~~ by provider.** (a) A health care provider, as defined in section 62J.03, subdivision 8, or the provider's designee as agreed to by that designee, shall, at the request of a consumer, and at no cost to the consumer or the consumer's employer, provide that consumer with a good faith estimate of the allowable payment the provider has agreed to accept from the consumer's health plan company for the services specified by the consumer, specifying the amount of the allowable payment due from the health plan company. ~~Health plan companies must allow contracted providers, or their designee, to release this information.~~ If a consumer has no applicable public or private coverage, the health care provider must give the consumer, and at no cost to the consumer, a good faith estimate of the average allowable reimbursement the provider accepts as payment from private third-party payers for the services specified by the consumer and the estimated amount the noncovered consumer will be required to pay.

(b) In addition to the information required to be disclosed under paragraph (a), a provider must also provide the consumer with information regarding other types of fees or charges that the consumer may be required to pay in conjunction with a visit to the provider, including but not limited to any applicable facility fees.

(c) The information required under this subdivision must be provided to a consumer within ten business days from the day a complete request was received by the health care provider. For purposes of this section, "complete request" includes all the patient and service information the health care provider requires to provide a good faith estimate, including a completed good faith estimate form if required by the health care provider.

(d) Payment information provided by a provider, or by the provider's designee as agreed to by that designee, to a patient pursuant to this subdivision does not constitute a legally binding estimate of the allowable charge for or cost to the consumer of services.

(e) No contract between a health plan company and a provider shall prohibit a provider from disclosing the pricing information required under this subdivision.

Subd. 1a. **Required disclosure by health plan company.** ~~(b)~~ (a) A health plan company, as defined in section 62J.03, subdivision 10, shall, at the request of an enrollee intending to receive specific health care services or the enrollee's designee, provide that enrollee with a good faith estimate of the allowable amount the health plan company has contracted for

S3480-3

A bill for an act

relating to health care; adding provisions to the price disclosure requirements for providers and health plan companies; amending Minnesota Statutes 2016, section 62J.81; proposing coding for new law in Minnesota Statutes, chapter 62J.

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

Section 1. Minnesota Statutes 2016, section 62J.81, is amended to read:

62J.81 DISCLOSURE OF PAYMENTS FOR HEALTH CARE SERVICES.

Subdivision 1. **Required disclosure ~~of estimated payment~~ by provider.** (a) A health care provider, as defined in section 62J.03, subdivision 8, or the provider's designee as agreed to by that designee, shall, at the request of a consumer, and at no cost to the consumer or the consumer's employer, provide that consumer with a good faith estimate of the allowable payment the provider has agreed to accept from the consumer's health plan company for the services specified by the consumer, specifying the amount of the allowable payment due from the health plan company. ~~Health plan companies must allow contracted providers, or their designee, to release this information.~~ If a consumer has no applicable public or private coverage, the health care provider must give the consumer, and at no cost to the consumer, a good faith estimate of the average allowable reimbursement the provider accepts as payment from private third-party payers for the services specified by the consumer and the estimated amount the noncovered consumer will be required to pay.

(b) In addition to the information required to be disclosed under paragraph (a), a provider must also provide the consumer with information regarding other types of fees or charges that the consumer may be required to pay in conjunction with a visit to the provider, including but not limited to any applicable facility fees.

(c) The information required under this subdivision must be provided to a consumer within ten business days from the day a complete request was received by the health care provider. For purposes of this section, "complete request" includes all the patient and service information the health care provider requires to provide a good faith estimate, including a completed good faith estimate form if required by the health care provider.

(d) Payment information provided by a provider, or by the provider's designee as agreed to by that designee, to a patient pursuant to this subdivision does not constitute a legally binding estimate of the allowable charge for or cost to the consumer of services.

(e) No contract between a health plan company and a provider shall prohibit a provider from disclosing the pricing information required under this subdivision.

Subd. 1a. **Required disclosure by health plan company.** ~~(b)~~ (a) A health plan company, as defined in section 62J.03, subdivision 10, shall, at the request of an enrollee intending to receive specific health care services or the enrollee's designee, provide that enrollee with a good faith estimate of the allowable amount the health plan company has contracted for

H3893-1		S3480-3	
2.17	with a specified provider within the network as total payment for a health care service	2.15	with a specified provider within the network as total payment for a health care service
2.18	specified by the enrollee and the portion of the allowable amount due from the enrollee and	2.16	specified by the enrollee and the portion of the allowable amount due from the enrollee and
2.19	the enrollee's out-of-pocket costs. An estimate provided to an enrollee under this paragraph	2.17	the enrollee's out-of-pocket costs. An estimate provided to an enrollee under this paragraph
2.20	is not a legally binding estimate of the allowable amount or enrollee's out-of-pocket cost.	2.18	is not a legally binding estimate of the allowable amount or enrollee's out-of-pocket cost.
2.21	(b) The information required under this subdivision must be provided by the health plan	2.19	(b) The information required under this subdivision must be provided by the health plan
2.22	company to an enrollee within ten business days from the day a complete request was	2.20	company to an enrollee within ten business days from the day a complete request was
2.23	received by the health plan company. For purposes of this section, "complete request"	2.21	received by the health plan company. For purposes of this section, "complete request"
2.24	includes all the patient and service information the health plan company requires to provide	2.22	includes all the patient and service information the health plan company requires to provide
2.25	a good faith estimate, including a completed good faith estimate form if required by the	2.23	a good faith estimate, including a completed good faith estimate form if required by the
2.26	health plan company.	2.24	health plan company.
2.27	Subd. 2. **Applicability.** (a) For purposes of this section, "consumer" does not include a	2.25	Subd. 2. **Applicability.** (a) For purposes of this section, "consumer" does not include a
2.28	medical assistance or MinnesotaCare enrollee, for services covered under those programs.	2.26	medical assistance or MinnesotaCare enrollee, for services covered under those programs.
2.29	(b) For purposes of this section, a good faith estimate is not:	2.27	(b) For purposes of this section, a good faith estimate is not:
2.30	(1) a guarantee of final costs for services received from a health care provider; or	2.28	(1) a guarantee of final costs for services received from a health care provider; or
2.31	(2) a final determination of eligibility for coverage of benefits or provider network	2.29	(2) a final determination of eligibility for coverage of benefits or provider network
2.32	participation under a health plan.	2.30	participation under a health plan.
2.33	**EFFECTIVE DATE.** This section is effective July 1, 2019.	2.31	**EFFECTIVE DATE.** This section is effective July 1, 2019.
3.1	Sec. 2. **[62J.812] PRIMARY CARE PRICE TRANSPARENCY.**	3.1	Sec. 2. **[62J.812] PRIMARY CARE PRICE TRANSPARENCY.**
3.2	(a) Each provider shall maintain a list of the services over $25 that correspond with the	3.2	(a) Each provider shall maintain a list of the services over $25 that correspond with the
3.3	provider's 25 most frequently billed current procedural terminology (CPT) codes, including	3.3	provider's 25 most frequently billed current procedural terminology (CPT) codes, including
3.4	the provider's ten most commonly billed evaluation and management codes, and of the ten	3.4	the provider's ten most commonly billed evaluation and management codes, and of the ten
3.5	most frequently billed CPT codes for preventive services. If the provider is associated with	3.5	most frequently billed CPT codes for preventive services. If the provider is associated with
3.6	a health care system, the health care system may develop the list of services required under	3.6	a health care system, the health care system may develop the list of services required under
3.7	this paragraph for the providers within the health care system.	3.7	this paragraph for the providers within the health care system.
3.8	(b) For each service listed in paragraph (a), the provider shall disclose the provider's	3.8	(b) For each service listed in paragraph (a), the provider shall disclose the provider's
3.9	charge, the average reimbursement rate received for the service from the provider's health	3.9	charge, the average reimbursement rate received for the service from the provider's health
3.10	plan payers in the commercial insurance market, and, if applicable, the Medicare allowable	3.10	plan payers in the commercial insurance market, and, if applicable, the Medicare allowable
3.11	payment rate and the medical assistance fee-for-service payment rate. For purposes of this	3.11	payment rate and the medical assistance fee-for-service payment rate. For purposes of this
3.12	paragraph, "provider's charge" means the dollar amount the provider charges to a patient	3.12	paragraph, "provider's charge" means the dollar amount the provider charges to a patient
3.13	who has received the service and who is not covered by private or public health care	3.13	who has received the service and who is not covered by private or public health care
3.14	coverage.	3.14	coverage.
3.15	(c) The list described in paragraph (a) must be updated annually and must be posted in	3.15	(c) The list described in this subdivision must be updated annually and must be posted
3.16	the provider's reception area of the clinic or office and made available on the provider's	3.16	in the provider's reception area of the clinic or office and made available on the provider's
3.17	Web site, if the provider maintains a Web site.	3.17	Web site, if the provider maintains a Web site.
3.18	(d) For purposes of this section, "provider" means a primary care provider or clinic that	3.18	(d) For purposes of this subdivision, "provider" means a primary care provider or clinic
3.19	specializes in family medicine, general internal medicine, gynecology, or general pediatrics.	3.19	that specializes in family medicine, general internal medicine, gynecology, or general
3.20	**EFFECTIVE DATE.** This section is effective July 1, 2019.	3.20	pediatrics.

3.21 (e) No contract between a health plan company and a provider shall prohibit a provider
3.22 from disclosing the pricing information required under this section.

3.23 **EFFECTIVE DATE.** This section is effective July 1, 2019.