SENATE
STATE OF MINNESOTA
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S.F. No. 250

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01/12/2023	175	Introduction and first reading Referred to Health and Human Services

A bill for an act

relating to health care; requiring health plan companies to develop and implement a shared savings incentive program; requiring a report; proposing coding for new law in Minnesota Statutes, chapter 62Q.

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

Section 1. **[62Q.05] SHARED SAVINGS INCENTIVE PROGRAM.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Allowed amount" means the contractually agreed upon amount paid for a health care service to a health care provider participating in the health plan company's provider network. The contractually agreed upon amount includes the amount paid to the provider by the health plan company and any cost-sharing required to be paid to the provider by the enrollee, including co-payments, deductibles, or coinsurance.

(c) "Average" means median or mean.

(d) "Commissioner" means the commissioner of health.

(e) "Comparable health care service" means a covered nonemergency health care service for which a health plan company offers a shared savings incentive payment pursuant to this section. Comparable health care services include, at a minimum, health care services within the following categories:

(1) physical and occupational therapy services;

(2) obstetrical and gynecological services;

(3) radiology and imaging services;

(4) laboratory services;

(5) infusion therapy services;

(6) inpatient and outpatient surgical procedures; and

(7) outpatient nonsurgical diagnostic tests and procedures.

The commissioner may limit what is considered a comparable health care service if a health plan company can demonstrate that the allowed amount variation for the service among in-network providers is less than $50.

(f) "Program" means the shared savings incentive program established by a health plan company pursuant to this section.

Subd. 2. **General.** (a) Beginning January 1, 2024, each health plan company offering a health plan in this state must offer a shared savings incentive program to its enrollees that meets the requirements of this section.

(b) Prior to offering the program, a health plan company must file with the commissioner a description of the program established by the health plan company pursuant to this section in a manner prescribed by the commissioner. The commissioner shall review the filing to ensure that the proposed program complies with the requirements of this section.

Subd. 3. **Cost information website.** (a) The commissioner shall develop a web-based interactive system for consumers to use to compare provider average charges for health care services by procedure or procedure code (CPT code). At a minimum, the health care services compared must include the comparable health care services defined under subdivision 1.

(b) Charges identified on the website do not constitute a legally binding estimate of the allowable charge for or cost to the consumer for the specific health care service, and the actual cost of the service may vary based on individual circumstances.

(c) The commissioner must contract with a private entity to satisfy the requirements of this subdivision.

Subd. 4. **Shared savings incentive account.** A health plan company must establish a shared savings incentive account for each enrollee. The health plan company shall deposit into the account any incentive payments earned by the enrollee through the program. Funds in the account may be withdrawn by the enrollee to pay any applicable co-payments, coinsurance, or deductibles. If an enrollee's out-of-pocket maximum has been met for the year or there are unused funds in the account at the end of the contract year, the enrollee

may withdraw the funds in the account to pay for premiums for the current contract year or the following contract year.

Subd. 5. **Program requirements.** (a) A health plan company must develop and implement a shared savings incentive program that provides incentives for an enrollee who receives a comparable health care service that is covered under the enrollee's health plan from a health care provider that charges less than the average allowed amount paid by that health plan company for that health care service. A health plan company may enter into a contract with a third-party entity to develop and implement the health plan company's shared savings incentive program.

(b) The program must provide an enrollee with at least 50 percent of the saved costs for each comparable health care service resulting in comparison shopping by the enrollee. A health plan company is not required to provide a payment to an enrollee if the health plan company's saved cost for a comparable health care service is $25 or less. Compliance with this paragraph may be demonstrated in the aggregate of health plans offered by the health plan company within the state based on a reasonably anticipated mix of claims.

(c) The incentive offered may be calculated as a percentage of the difference in the average allowed amount and the price paid or by using another reasonable methodology approved by the commissioner. The health plan company shall deposit any incentive earned by the enrollee into the enrollee's shared savings incentive account established under subdivision 4.

(d) A health plan company must determine a process for documenting that the provider chosen by an enrollee charges less for a comparable health care service than the average allowed amount paid by that health plan company. The health plan company may require the enrollee to demonstrate through reasonable documentation, such as a quote from the health care provider, that the enrollee comparison shopped prior to receiving care from a health care provider that charges less for the comparable health care service than the average allowed amount paid by the health plan company.

Subd. 6. **Allowed amount; disclosure.** (a) A health plan company may base the average allowed amount paid to an in-network health care provider for a comparable health care service on what is paid to an in-network health care provider applicable to the enrollee's specific health plan or across all of its health plans offered in the state. A health plan company may determine an alternative methodology for calculating the average allowed amount if approved by the commissioner.

(b) A health plan company must establish an interactive mechanism that enables an enrollee to request and obtain information from the health plan company on the payments made for comparable health care services, as well as quality data. The interactive mechanism must allow an enrollee to seek information about the cost of a specific comparable health care service in order to compare the average allowed amount paid to in-network health care providers based on the enrollee's health plan. The mechanism must also provide a good faith estimate of the anticipated charges and out-of-pocket costs an enrollee would be responsible to pay for a comparable health care service if provided by an in-network health care provider, including any co-payment, deductible, coinsurance or other out-of-pocket amount, based on the enrollee's health plan and information available to the health plan company at the time the request is made. A health plan company may contract with a third-party vendor to satisfy this requirement.

(c) A health plan company must inform an enrollee of the enrollee's ability to request the average allowed amount paid for a comparable health care service on the health plan company's website and in the health plan benefits materials.

Subd. 7. **Out-of-network provider.** (a) If an enrollee elects to receive a comparable health care service from an out-of-network provider at a price that is less than the average allowed amount paid by the enrollee's health plan company to an in-network provider, then the health plan company must allow the enrollee to obtain the health care service from the out-of-network provider at the out-of-network provider's price. Upon request of the enrollee, the health plan company must apply the payments made by the enrollee for that health care service toward the enrollee's deductible and out-of-pocket maximum as specified by the enrollee's health plan as if the health care service had been provided by an in-network provider. If the enrollee's deductible has been met, the enrollee may submit the claim to the health plan company and the health plan company must pay the claim in the same manner as claims submitted by an in-network provider.

(b) If the enrollee directly pays the out-of-network provider, a health plan company must provide a downloadable or interactive online form to the enrollee for submitting proof of payment to an out-of-network provider for purposes of administering this subdivision.

Subd. 8. **Notice to enrollees by health plan company.** (a) A health plan company must make the program available as a component to any health plan offered by the health plan company to a Minnesota resident. Upon enrollment and annually upon renewal, a health plan company must provide notice to each enrollee of the availability of the program, a description of the incentives available to an enrollee, how an enrollee can earn those incentives, and the comparable health care services that may qualify for a shared savings

incentive payment. The notice must inform enrollees of the right to obtain services from a different health care provider, regardless of any referral or recommendation made by a specific health care provider or entity, and that seeing a different health care provider, either the health care provider to which the referral was made or a different health care provider, may result in an incentive to the enrollee if the enrollee follows the steps set by the enrollee's health plan company.

(b) The health plan company must also provide this information on the health plan company's website.

Subd. 9. **Notice to enrollee by provider.** Health care providers must post in a visible area notification of a patient's ability, for those with individual or small group coverage, to obtain a description of the service or the applicable standard medical codes or current procedural terminology codes sufficient to allow a health plan company to assist the patient in comparing out-of-pocket and contracted amounts paid for the patient's care to different health care providers for similar services. The notification must notify the patient that the patient's health plan company is required to provide enrollees with an estimate of the out-of-pocket costs and the average allowed amount paid for the patient's care. A health care provider may provide additional information to a patient that informs the patient of specific price transparency mechanisms or websites that may be available to the patient.

Subd. 10. **No administrative expense.** A shared savings incentive payment made by a health plan company according to this section is not an administrative expense of the health plan company for purposes of rate development or rate filing and may be considered a medical expense for purposes of medical loss ratio requirements.

Subd. 11. **Exclusions.** This section does not apply to health plans offered to enrollees who are enrolled in a public health care program under chapter 256B or 256L.

Subd. 12. **Report.** (a) By March 1 of each year, beginning March 1, 2025, a health plan company must file with the commissioner for the previous calendar year:

(1) the total number of shared savings incentive payments made pursuant to this section;

(2) the use of comparable health care services by category of service for which shared savings incentive payments were made;

(3) the average amount of shared savings incentive payments made by category of service;

(4) the total savings achieved below the average prices by category of service; and

(5) the total number and percentage of the health plan company's enrollees who participated in the program.

(b) By April 15 of each year, beginning April 15, 2025, the commissioner of health shall submit an aggregate report containing the information submitted under paragraph (a) by the health plan companies to the chairs and ranking minority members of the legislative committees with jurisdiction over health insurance.

Subd. 13. **Citation.** This section may be cited as the "Patient Right To Shop Act."