SENATE
STATE OF MINNESOTA
NINETIETH SESSION

S.F. No. 3480

(SENATE AUTHORS: DRAHEIM and Jensen)

DATE	D-PG	OFFICIAL STATUS
03/15/2018	6525	Introduction and first reading
		Referred to Commerce and Consumer Protection Finance and Policy
03/21/2018	6818a	Comm report: To pass as amended and re-refer to Health and Human Services Finance and Policy
	6878	Author added Jensen
04/09/2018	7242a	Comm report: To pass as amended
		Joint rule 2.03, referred to Rules and Administration
04/16/2018	7310	Comm report: Adopt previous comm report Joint rule 2.03 Suspended
	7311	Second reading
05/01/2018	8501a	Special Order: Amended
	8501	Third reading Passed
05/16/2018	8990	Returned from House
		Presentment date 05/16/18
	10617	Governor's action Approval 05/19/18
	10618	Secretary of State Chapter 168 05/19/18
		Effective date 07/01/19

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 with a specified provider within the network as total payment for a health care service specified by the enrollee and the portion of the allowable amount due from the enrollee and the enrollee's out-of-pocket costs. An estimate provided to an enrollee under this paragraph is not a legally binding estimate of the allowable amount or enrollee's out-of-pocket cost.

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

Subd. 2. **Applicability.** (a) For purposes of this section, "consumer" does not include a medical assistance or MinnesotaCare enrollee, for services covered under those programs.

(b) For purposes of this section, a good faith estimate is not:

(1) a guarantee of final costs for services received from a health care provider; or

(2) a final determination of eligibility for coverage of benefits or provider network participation under a health plan.

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

Sec. 2. **[62J.812] PRIMARY CARE PRICE TRANSPARENCY.**

(a) Each provider shall maintain a list of the services over $25 that correspond with the provider's 25 most frequently billed current procedural terminology (CPT) codes, including the provider's ten most commonly billed evaluation and management codes, and of the ten most frequently billed CPT codes for preventive services. If the provider is associated with a health care system, the health care system may develop the list of services required under this paragraph for the providers within the health care system.

(b) For each service listed in paragraph (a), the provider shall disclose the provider's charge, the average reimbursement rate received for the service from the provider's health plan payers in the commercial insurance market, and, if applicable, the Medicare allowable payment rate and the medical assistance fee-for-service payment rate. For purposes of this paragraph, "provider's charge" means the dollar amount the provider charges to a patient who has received the service and who is not covered by private or public health care coverage.

(c) The list described in this subdivision must be updated annually and must be posted in the provider's reception area of the clinic or office and made available on the provider's Web site, if the provider maintains a Web site.

(d) For purposes of this subdivision, "provider" means a primary care provider or clinic that specializes in family medicine, general internal medicine, gynecology, or general pediatrics.

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

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