SENATE
STATE OF MINNESOTA
NINETY-THIRD SESSION

S.F. No. 221

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DATE	D-PG	OFFICIAL STATUS
01/12/2023	170	Introduction and first reading Referred to Health and Human Services

A bill for an act

relating to health; modifying requirements for information on patient medical bills; establishing health care price transparency requirements; amending Minnesota Statutes 2022, sections 62J.701; 62J.72, subdivision 3; 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 2022, section 62J.701, is amended to read:

62J.701 GOVERNMENTAL PROGRAMS.

~~(a) Beginning January 1, 1999, the provisions in paragraphs (b) to (e) apply.~~

~~(b)~~ (a) For purposes of sections 62J.695 to 62J.80, the requirements and other provisions that apply to health plan companies also apply to governmental programs.

~~(c)~~ (b) For purposes of this section, "governmental programs" means the medical assistance program, the MinnesotaCare program, the state employee group insurance program, the public employees insurance program under section 43A.316, and coverage provided by political subdivisions under section 471.617.

~~(d)~~ (c) Notwithstanding paragraph ~~(b)~~ (a), section 62J.72 does not apply to the fee-for-service programs under medical assistance and MinnesotaCare and section 62J.72, subdivision 3, paragraph (b), does not apply to the prepaid medical assistance program or MinnesotaCare.

~~(e)~~ (d) If a state commissioner or local unit of government contracts with a health plan company or a third-party administrator, the contract may assign any obligations under paragraph ~~(b)~~ (a) to the health plan company or third-party administrator. Nothing in this

paragraph shall be construed to remove or diminish any enforcement responsibilities of the commissioners of health or commerce provided in sections 62J.695 to 62J.80.

Sec. 2. Minnesota Statutes 2022, section 62J.72, subdivision 3, is amended to read:

Subd. 3. **Information on patients' medical bills.** (a) A health plan company and health care provider shall provide patients and enrollees with a copy of an explicit and intelligible bill ~~whenever the patient or enrollee is sent a bill and is responsible for paying any portion of that bill~~. The ~~bills~~ bill must contain descriptive language sufficient to be understood by the average patient or enrollee. This subdivision does not apply to a flat co-pay paid by the patient or enrollee at the time the service is required.

(b) In addition to the requirements in paragraph (a), when a health care provider transmits a bill to a patient, the bill must specify the following for the health care services provided:

(1) the dollar amount the provider is willing to accept as payment in full;

(2) the Medicare-allowable fee-for-service payment rate; and

(3) the provider's Medicare percent, as defined in section 62J.85, subdivision 1.

For patients covered by a health plan, a provider must also include a copy of the Medicare percent disclosure form signed by the patient or the patient's representative, as required under section 62J.85, subdivision 5.

Sec. 3. **[62J.85] HEALTH CARE PRICE TRANSPARENCY; NOTICE AND DISCLOSURE OF MEDICARE PERCENT.**

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

(b) "Health plan" has the meaning given in section 62A.011, subdivision 3, and does not include coverage provided under medical assistance, MinnesotaCare, or Medicare Part A, Part B, or Part C.

(c) "Medicare percent" means the percentage of the Medicare allowable payment rate that a health care provider accepts as payment in full for health care services provided by that provider.

Subd. 2. **Additional required disclosures by provider.** (a) Before a health care provider provides any health care services to a patient, the provider or the provider's designee, as agreed to by that designee, must determine whether the proposed health care services are covered by the patient's health plan. If any of the health care services are not covered by

the patient's health plan, the provider or the provider's designee must provide the patient with a notice specifying the services not covered by the patient's health plan and must retain a copy of the notice signed by the patient. If a provider fails to disclose to a patient that a service is not covered, the provider is prohibited from billing the patient for that noncovered service. If a provider complies with the disclosure and signature requirements of this paragraph, and the patient receives the noncovered services from the provider, the patient must pay for the services received.

(b) In addition to the information required to be disclosed under paragraph (a), before a health care provider provides any health care services to a patient, the provider or the provider's designee, as agreed to by that designee, must determine whether the provider participates in the provider network for the patient's health plan and must disclose the provider's network participation status to the patient. If the provider does not participate in the provider network for the patient's health plan, the provider must obtain a signed acknowledgment from the patient indicating that the patient understands the provider is out-of-network. If the provider fails to obtain the signed acknowledgment from the patient under this paragraph, the provider shall not bill the patient for services provided to the patient for any amount that is in addition to the amount authorized for the services in the in-network average fee schedule of the patient's health plan.

Subd. 3. **Required notice.** (a) A health care provider must establish a Medicare percent that the provider will accept as payment in full for health care services provided by that provider. A provider must provide notice to patients and the public of the provider's Medicare percent by:

(1) posting information describing the Medicare percent and specifying the provider's Medicare percent in a prominent, clearly visible location at or near the provider's reception desk, registration desk, or patient check-in area;

(2) posting information describing the Medicare percent and specifying the provider's Medicare percent on the provider's public website; and

(3) including information describing the Medicare percent and specifying the provider's Medicare percent on any document related to provider payments that the provider requires a patient or patient's representative to sign.

(b) The notices required in paragraph (a) must include the following statement: "The Medicare percent means the percentage of Medicare reimbursement that this provider will accept as payment in full for services provided to patients. The Medicare percent can be used by a patient to compare the cost of care between providers.

Subd. 4. **Application of hospital's, health care facility's, or clinic's Medicare percent to employed, affiliated, or contracted providers.** A health care provider employed by, affiliated with, or under contract with a hospital, health care facility, or medical clinic shall not be reimbursed at an amount greater than the amount of the hospital's or clinic's Medicare percent.

Subd. 5. **Medicare percent disclosure form.** (a) Before providing health care services to a patient, a health care provider must:

(1) provide the patient or patient's representative with a Medicare percent disclosure form describing the Medicare percent; and

(2) obtain the signature of the patient or patient's representative on a copy of the form retained by the provider.

The Medicare percent disclosure form of a hospital, health care facility, or medical clinic must also include the following statement in 12-point, bold type: "ALL PROVIDERS OF HEALTH CARE SUPPORT SERVICES, INCLUDING SERVICES PROVIDED BY HEALTH PROFESSIONALS, THAT FORM A PART OF THE HEALTH CARE FOR PATIENTS AT THIS FACILITY OR CLINIC HAVE AGREED TO ACCEPT THE FACILITY'S OR CLINIC'S MEDICARE PERCENT AS PAYMENT IN FULL FOR THEIR SERVICES." Except as provided in paragraph (c), if a provider fails to provide a patient or patient's representative with the disclosure form required by this paragraph, the provider is subject to a $1,000 fine to be paid to the patient or credited to the patient's account with the provider.

(b) For patients covered by a health plan, a provider must include a copy of the disclosure form signed by the patient or patient's representative with all bills submitted to a health plan company. If a provider fails to include a copy of the signed disclosure form in a bill submitted to a health plan company, the provider shall not be reimbursed at an amount greater than the Medicare-allowable payment rate for the services listed on the provider's bill as payment in full for those services.

(c) A provider shall be reimbursed at no more than ..... percent of the Medicare-allowable payment rate for a specific health care service or at the provider's disclosed Medicare percent, whichever is less, if a provider fails to provide a patient or patient's representative with the disclosure form required in paragraph (a) because:

(1) the patient is unconscious or incapacitated and unable to sign the disclosure form; and

(2) no representative for the patient is present at the time health care services are provided to the patient.