SENATE
STATE OF MINNESOTA
NINETIETH SESSION

S.F. No. 3033

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DATE	D-PG	OFFICIAL STATUS
03/08/2018	6351	Introduction and first reading Referred to Commerce and Consumer Protection Finance and Policy

A bill for an act

relating to health care; requiring health care providers and health plan companies to provide price transparency to patients and enrollees; proposing coding for new law in Minnesota Statutes, chapter 62J; repealing Minnesota Statutes 2016, section 62J.81.

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

Section 1. **[62J.812] HEALTH CARE PRICE TRANSPARENCY.**

Subdivision 1. **Most frequent charges disclosure.** (a) Each health care provider shall maintain a list of the services that correspond with the provider's 25 most frequently billed current procedural terminology (CPT) codes, including the provider's five most commonly billed evaluation and management codes, that are billed for over $25, and of the ten most frequently billed CPT codes for preventive services.

(b) For each service listed in paragraph (a), the provider shall disclose the provider's charge, the reimbursement rate received for the service from the provider's highest volume health plan payer 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 subdivision, "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, "health care provider" means a primary care provider or clinic that specializes in family medicine, general internal medicine, gynecology, or general pediatrics.

Subd. 2. **Estimated payment disclosure by provider.** (a) Each provider, upon request of a patient, shall provide the patient with a good faith estimate of the allowable payment that the provider has agreed to accept from the patient's health plan company for a specific procedure or service identified by the patient specifying the amount of the allowable payment due from the health plan company. If the patient is not covered by private or public health care coverage, or the provider is out of network, the provider must give the patient a good faith estimate of the amount the patient would be required to pay for the specified procedure or service. Payment information provided by a provider to a patient according to this paragraph does not constitute a legally binding estimate of the allowable charge for or cost to the patient for a specified procedure or service.

(b) In addition to the information required under paragraph (a), a provider must also provide the patient with information regarding other types of fees or charges a patient may be required to pay in conjunction with a visit to the provider or facility where the procedure or service would be performed.

(c) No contract between a health plan company and a health care provider shall contain a provision prohibiting the provider from disclosing negotiated pricing information, including information on out-of-pocket expenses.

(d) For purposes of this subdivision, "provider" has the meaning given in section 62J.03, subdivision 8. For purposes of this subdivision, "allowable payment" means the maximum reimbursement dollar amount that a patient's health plan allows for a specific procedure or service.

Subd. 3. **Estimated payment disclosure by health plan.** (a) A health plan company shall develop a Web site and toll-free telephone number that enables an enrollee to request and obtain a good faith estimate of the total payment amount the health plan company has negotiated with an in-network provider for a specified procedure or service, including inpatient admissions for nonemergency care and the portion of the total payment amount that is the responsibility of the enrollee. An estimate provided to an enrollee under this paragraph is not a legally binding estimate of the total payment amount or an enrollee's out-of-pocket cost.

(b) Access to the company's Web site and telephone number shall be available to each enrollee at no extra cost to the enrollee and must permit an enrollee to obtain the information

under this subdivision in a format that allows an enrollee to enter the enrollee's specific health plan, the hospital or health care clinic or provider, and the procedure or service.

(c) For purposes of this subdivision, "total payment amount" means the amount the provider expects to be paid from the health plan company and the patient for providing a procedure or service.

Sec. 2. **REPEALER.**

Minnesota Statutes 2016, section 62J.81, is repealed.

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

Subdivision 1. **Required disclosure of estimated payment.** (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. 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.

(b) 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.

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