HOUSE RESEARCH

Bill Summary

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Overview

This bill modifies requirements for good-faith estimates of payments for health care services that health care providers and health plan companies must provide to consumers. It also requires primary care providers to make publicly available, price information for commonly billed services.

Section

1 **Disclosure of payments for health care services.** Amends § 62J.81.

Subd. 1. Required disclosure by provider. Current law requires a health care provider to provide a consumer with (1) a good faith estimate of the payment the provider has agreed to accept from the consumer's insurer for a health care service or (2) if the consumer has no insurance, a good faith estimate of the average allowable reimbursement the provider accepts as payment for the service from insurers.

A new paragraph (b) also requires a provider to give a consumer information on other types of fees or charges the consumer may have to pay when seeing the provider, such as facility fees.

A new paragraph (c) requires providers to give consumers information required under this subdivision within 10 business days from the day the provider receives a complete request from a consumer.

Paragraph (e) provides that contracts between health plan companies and providers cannot prohibit a provider from disclosing the price information required by this subdivision (this language is similar to language being stricken in paragraph (a)).

Section

Subd. 1a. Required disclosure by health plan company. Current law requires a health plan company to provide an enrollee with a good-faith estimate of the allowable amount the health plan company will pay a specific provider for a health care service, and the amount due from the enrollee.

A new paragraph (b) requires the information required under this subdivision to be provided by the health plan company within 10 business days from the day the health plan company receives a complete request.

Subd. 2. Applicability. Specifies that a good faith estimate provided under this section is not a guarantee of final costs for a service, or a final determination of eligibility for coverage or provider network participation.

2 **Primary care price transparency.** Adds § 62J.812. Paragraph (a) requires a provider to maintain a list of services over $25 that correspond to the provider's 25 most frequently billed current procedural terminology (CPT) codes and the provider's 10 most frequently billed CPT codes for preventive services. Allows a health care system to develop this list, for providers associated with a health care system.

Paragraph (b) requires the provider to disclose the following for each service on the list developed in paragraph (a):

- the provider's charge for the service (this is the amount the provider charges to a patient who is not covered by public or private health coverage);
- 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 MA fee-for-service payment rate.

Paragraph (c) requires the list to be updated annually, posted in the provider's reception area, and made available on the provider's Web site, if any.

Paragraph (d) defines provider as a primary care clinic or provider in family medicine, general internal medicine, gynecology, or general pediatrics.