2021 Health Care Legislative and Special Session Summary

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Executive Summary

After a tumultuous and contentious year, legislators were not able to pass a budget by the end of the regular 2021 legislative session deadline. On the day session ended, May 17, Legislative leadership and the Governor announced that they had reached an agreement on budget targets, confirming that a Special Session would be required to finish the Legislature's work.

The agreement stated that all but $500 million of the $2.8 billion in federal funding from the American Rescue Plan (ARP) that Minnesota had received would be spent by the Legislature, which gave Republicans and Democrats the wiggle room necessary to fulfill the GOP's goal of passing no new taxes and the DFL's priority to significantly increase funding for schools. The agreement also included full PPP loan conformity and a breakdown of how much money each omnibus bill could spend.

The Special Session began on June 14, 2021 with the Governor extending his emergency powers for another 30 days. Senate Majority Leader Gazelka introduced a continuing resolution the first day that would allow for base level funding if there were any conference committees that did not come to an agreement, a sign that budget deadlines in a divided Legislature could continue to be missed. Lawmakers in working groups missed their self-imposed deadlines to have budget and language agreements, but were able to begin putting their agreements together throughout the month of June.

The House Republican minority, in an effort to display their frustration with being left out of the negotiation process and to find leverage on some of their core policy issues, filibustered several bills on the House floor, including setting a new record for debate by speaking on the Omnibus Commerce bill for 23 hours in total. The Democrats admonished them for holding up the state's important work to pass a budget and avoid a government shutdown, but Minority Leader Daudt pushed back by saying that since the omnibus bills were not properly vetted in committee, that they would need to be thoroughly discussed on the floor. However, as the June 30 deadline approached and Democrats chose to renew reinsurance for the next year – a high priority for the Republicans - the process became much smoother and agreements were made with budget bills being passed in both chambers.

All budget bills were passed by the late hours of June 30, which stopped the Legislature from entering a state shutdown. Just before midnight June 29, the Governor and Legislative leaders announced an agreement to end the Governor's Emergency Powers on July 1, a major goal of the Republicans. While Governor Walz had planned on ending the Peacetime Emergency by August 1, Republicans felt that it was unnecessary for Walz to retain that authority for another month. As part of the negotiations, Governor Walz agreed to move up the end date to July 1, if the agreement would include the ability for the Health and Human Services Commissioners to declare a public health disaster in relation to COVID, to continue some of the executive orders related to unemployment insurance and state employee COVID staffing until August 1, to allow the Governor to continue to manage vaccination and testing, to have an off-ramp in place regarding the eviction moratorium, and to preserve his ability to declare another emergency if necessary. After 16 months, the state is no longer under a peacetime emergency as of July 1, 2021.

Looking Ahead

With all budget bills passed, the House of Representatives adjourned sine die at 2:00 am on July 1. The Senate adjourned sine die on Tuesday, July 7th after holding a few hearings regarding the confirmations of a few commissioners. Laura Bishop, the Commissioner of the MN Pollution Control Agency, was rumored to be one of the commissioners that the Senate Republican majority was unhappy with, and she resigned before they could vote on her confirmation.

With the Governor's peacetime emergency ended, the Legislature no longer needs to be called back into session each month to renew his authority. However, the Legislature created a working group to make recommendation on how to compensate essential workers for their work during the pandemic. This working group must report back to the Legislature at the end of the summer, and there will likely be a Special Session in September so that the Legislature can appropriate the funds.

The 2022 legislative session will begin on January 31, 2022. The primary focus of this session will be passage of a bonding bill, drawing new legislative districts, and allocating federal American Rescue Plan money that the Governor and legislative leaders agreed to set aside as part of this year's budget agreement. Since 2022 is an election year, the 2022 session is likely to be contentious since all legislators will be on the ballot with new lines from redistricting and a likely hotly contested Gubernatorial election.

Legislation of Interest That Passed

HHS Policy Provisions – Regular Session

Representative Liebling/Senator Benson
View the Conference Committee Summary here.

Health and Human Services is often the longest of all of the omnibus bills, and this year was no different with the House bill exceeding 800 pages. Without Joint Budget Targets, the leaders of the Health and Human Services Conference Committee spent their time in the last weeks of session working to find a compromise on the policy provisions of the bill. On the last day of session the Health and Human Services Omnibus Policy Bill passed on a bipartisan basis.

The bill has almost no fiscal impact. The bill defines "provider credentialing" and creates a timeline for the provider credentialing process to expand access to care. The bill expands the medical use cannabis program to allow terminally ill patients to use cannabis flower which they were previously not able to use. The bill expands the number of patients that designated caregivers can be registered as the designated caregiver from one patient to up to six.

Provider Credentialing Language:

Section 1. **[62Q.097] REQUIREMENTS FOR TIMELY PROVIDER CREDENTIALING.**
Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Clean application for provider credentialing" or "clean application" means an application for provider credentialing submitted by a health care provider to a health plan company that is complete, is in the format required by the health plan company, and includes all information and substantiation required by the health plan company and does not require evaluation of any identified potential quality or safety concern.

(c) "Provider credentialing" means the process undertaken by a health plan company to evaluate and approve a health care provider's education, training, residency, licenses, certifications, and history of significant quality or safety concerns in order to approve the health care provider to provide health care services to patients at a clinic or facility.

Subd. 2. Time limit for credentialing determination. A health plan company that receives an application for provider credentialing must:

1) if the application is determined to be a clean application for provider credentialing and if the health care provider submitting the application or the clinic or facility at which the health care provider provides services requests the information, affirm that the health care provider's application is a clean application and notify the health care provider or clinic or facility of the date by which the health plan company will make a determination on the

health care provider's application;

(2) if the application is determined not to be a clean application, inform the health care provider of the application's deficiencies or missing information or substantiation within three business days after the health plan company determines the application is not a clean application; and

(3) make a determination on the health care provider's clean application within 45 days after receiving the clean application unless the health plan company identifies a substantive quality or safety concern in the course of provider credentialing that requires further investigation. Upon notice to the health care provider, clinic, or facility, the health plan company is allowed 30 additional days to investigate any quality or safety concerns.

EFFECTIVE DATE. This section applies to applications for provider credentialing submitted to a health plan company on or after January 1, 2022.

Health and Human Services Omnibus Bill

Representative Liebling/Senator Benson
View the bill Summary here.
Chapter 7

The Health and Human Services (HHS) omnibus bill is one of the most complex budget areas for the State of Minnesota. During the regular session, the HHS Conference Committee chose to work on policy and passed a policy bill on the final day of the regular session that included a timeline for provider credentialing and expanded Minnesota's medical cannabis program.

The "working group" for the HHS omnibus bill met one time publicly between the regular session and the Special Session to hear from the Department of Health and Human Services on how federal dollars could be used on HHS matters. Major provisions that passed are below:

Health Provisions

- Expands Minnesota's telehealth practices including clarifications as to what can be covered including substance use issues and mental health evaluations, extends Medical Assistance Coverage to telemonitoring services, and includes audio only coverage through July 2023.
- Extends Medical Assistance postpartum coverage from 60 days to 12 months postpartum
- Provides Medical Assistance coverage for treatment, testing, and vaccination for COVID-19 as required under the American Rescue Plan.
- Requires health plan companies and third-party administrators to report encounter data and pricing data to the all-payer claims database on a monthly basis.
- Requires public notice and hearing before the closure and relocation of a hospital.
- Requires hospitals that provide obstetric care and birth centers to provide continuing education on implicit bias, and authorizes the health commissioner to conduct maternal morbidity studies.

- Requires coverage of weight-loss drugs under the state's Medical Assistance program, which are currently not covered.
- Allocates $150 million to the reinsurance program to extend the program another year.

Human Services Provisions

- Authorizes a$435 one-time payments to families in the state's Minnesota Family Investment Program (MFIP), a welfare program for low-income families.
- Creates a cost-of-living increase for MFIP recipients, as well as an additional $40 per month housing benefit.
- Requires courts to appoint a lawyer in all child protection cases for parents who cannot afford one.
- Clarifies and shortens the list of criminal convictions that prevent prospective foster parents from obtaining a license.
- Invests $250 million into the state's personal care attendant program including a service rate increase.
- Creates a sober housing oversight study.
- Invests $300 million in grants for child care providers.
- Increases the CCAP rates to the 40th percentile of market rates for infants and toddlers, and 30th percentile of market rates for older for older children.
- Creates a Great Start for All Minnesota Children Task Force that will develop a ten-year plan for affordable, high-quality early care and learning for all families, with livable wages for teachers.

For ASCs: All Claims Database Language in HHS Omnibus

144.693 MEDICAL MALPRACTICE CLAIMS; REPORTS.

Subdivision 1. **Insurers' reports to commissioner.**

On or before September 1, 1976, and on or before March 1 and September 1 of each year thereafter, each insurer providing professional liability insurance to one or more hospitals, outpatient surgery centers, or health maintenance organizations, shall submit to the state commissioner of health a report listing by facility or organization all claims which have been closed by or filed with the insurer during the period ending December 31 of the previous year or June 30 of the current year. The report shall contain, but not be limited to, the following information:

(1) the total number of claims made against each facility or organization which were filed or closed during the reporting period;

(2) the date each new claim was filed with the insurer;

(3) the allegations contained in each claim filed during the reporting period;

(4) the disposition and closing date of each claim closed during the reporting period;

(5) the dollar amount of the award or settlement for each claim closed during the reporting period; and

(6) any other information the commissioner of health may, by rule, require.

Any hospital, outpatient surgery center, or health maintenance organization which is self insured shall be considered to be an insurer for the purposes of this section and shall comply with the reporting provisions of this section.

A report from an insurer submitted pursuant to this section is private data, as defined in section 13.02, subdivision 12, accessible to the facility or organization which is the subject of the data, and to its authorized agents. Any data relating to patient records which is reported to the state commissioner of health pursuant to this section shall be reported in the form of summary data, as defined in section 13.02, subdivision 19.

Subd. 2. **Report to legislature.**
The state commissioner of health shall collect and review the data reported pursuant to subdivision 1. On December 1, 1976, and on January 2 of each year thereafter, the state commissioner of health shall report to the legislature the findings related to the incidence and size of malpractice claims against hospitals, outpatient surgery centers, and health maintenance organizations, and shall make any appropriate recommendations to reduce the incidence and size of the claims. Data published by the state commissioner of health pursuant to this subdivision with respect to malpractice claims information shall be summary data within the meaning of section 13.02, subdivision 19.

Subd. 3. **Access to insurers' records.**
The state commissioner of health shall have access to the records of any insurer relating to malpractice claims made against hospitals, outpatient surgery centers, and health maintenance organizations in years prior to 1976 if the commissioner determines the records are necessary to fulfill the duties of the commissioner under Laws 1976, chapter 325.

Provisions that did not pass in the HHS Omnibus Bill:

- Paid sick leave for health care employees
- Nurse licensure compact
- Repeal of the provider tax
- No-cost diagnostic services and testing following a mammogram
- COVID-19 immunity liability
- Physician non-compete covenant
- Athletic trainers modification
- Price transparency legislation (see bills that did not pass section)

Tax Omnibus Bill

Representative Marquart/Senate Nelson
View the bill summary here.

The Tax Committee received a $754 million General Fund spending target for FY 21-23, the largest of any committee. This target allowed the House and Senate to fund many of their top priorities in the final Special Session Tax Bill without raising any taxes. Most importantly, the final Special Session bill exempted PPP Loans from taxation and established a working group to provide guidance on how to disburse the $250 million in federal funding available to essential frontline workers. The bill also exempted $10,200 of unemployment compensation from taxes for people with AGI over $150,000. The bill did not include a 5th tier income tax increase or any corporate tax increases.

The Special Session Tax Bill reflected a compromise between House and Senate bills that started out with significant differences. The House Regular Session Tax Bill raised significant new revenue (over $1 billion in FY22-23) and used the revenue for targeted tax reductions and increases in aids and tax credits. Overall, the Regular Session House Tax Bill was revenue neutral with a $0 General Fund Budget Target. The Senate Regular Session Tax Bill did not raise new revenue and instead used $681 million of General Fund dollars to provide tax relief.

Included in the final Tax Bill:

Credits, Deductions, Exemptions

- Full conformity on PPP loans
- $10,200 of Unemployment Compensation exempted from taxes for those making under $150,000.
- Historic Tax Credit sunset extended for one year.
- Film Production Credit funded
- SALT pass through entity work around
- Minnesota Housing Tax Credit created
- Angel Investor Tax Credit extended for one year

Direct Appropriations/ Tax Administration/ Miscellaneous

- Creates a new targeted community capital project grant program for $24 million in grants to government entities and nonprofit organizations and updating the long summary that provide services in one or more of several specified areas. Grantees under article 3 of the 2020 bonding bill are also eligible in fiscal year.
- Establishes a working group to make recommendations to the Legislature on the disbursement of $250 million in financial support to frontline workers.
- Appropriates $6.2 million in fiscal year 2022 to the commissioner of transportation for project development of a land bridge over I-94 in St. Paul.
- $20 million per year for six years for a new homelessness prevention fund for counties, beginning in 2023
- Prohibits legislators from taking jobs at organizations whose primary purpose is lobbying
- Provides Governor Walz a limited authority to manage the COVID-19 pandemic after his emergency powers end.
- Partnership Audits compromise language

Property Taxes

- State General Levy decrease of $20 million by increasing the market value exclusion on the statewide property tax from $100,000 to $150,000
- Energy improvement assessments authorized
- TIF Flexibility:
    - TIF flexibility to directly help businesses
    - Extends the five-year rule to eight years for redevelopment districts certified after December 31, 2017, through June 30, 2020
    - Flexibility for TIF pooling in certain cases for owner-occupied homes

- 4d Property Tax Rate Changes: Sets the first tier limit for 4d property at $100,000. After assessment year 2023, the tier limit will be adjusted annually. Requires a report on class 4d property and on local 4d affordable housing programs.
- Adds a supplemental statement to the notice of proposed property taxes. This statement must contain the percent change in levy proposed for the following year by the county, city or township, and school district; and summary budget information for the county, city, and school district. Effective for property taxes payable in 2022.

Sales Taxes

- Provides a sales tax exemption for construction materials used or consumed in construction of local public safety facilities.
- June Accelerated Payments phase out
- New requirement for Local Options Sales Taxes: Creates a definition of "capital project" for which revenues collected from a general local tax may be used.

Language on $250 million for frontline workers:

Sec. 38. **FRONTLINE WORKER PAY WORKING GROUP.**

Subdivision 1.

Establishment.

A working group is established to make recommendations to the legislature on the disbursement of $250,000,000 in direct financial support to frontline workers.

Subd. 2.

Membership.

(a) The working group consists of nine members:

(1) two members of the house of representatives appointed by the speaker of the house of representatives;

(2) one member of the house of representatives appointed by the minority leader of the house of representatives;

(3) two members of the senate appointed by the senate majority leader;

(4) one member of the senate appointed by the minority leader of the senate; and

(5) three members representing the executive branch appointed by the governor.

(b) All appointments under this subdivision must be made by July 15, 2021. The working group must elect a chair and vice-chair from among its members.

Subd. 3.

Duties.

The working group must make a recommendation for the disbursement of $250,000,000 in direct financial support to frontline workers, including but not limited to long-term care workers. In developing its recommendation, the working group must consider factors including a frontline worker's increased financial burden and increased risk of virus exposure due to the nature of their work.

Subd. 4.

Meetings; administrative support.

The speaker of the house must designate one member to convene the first meeting. Meetings of the working group must be open to the public. The Legislative Coordinating Commission must provide physical or electronic meeting space and other administrative support as requested by the working group.

Subd. 5.

Submission of legislation.

(a) The working group must submit proposed legislative language implementing its recommendations to the governor, speaker of the house, and senate majority leader by September 6, 2021. For the working group to adopt a recommendation, seven of nine members must vote to approve it.

(b) If seven of nine members do not approve a single recommendation, then the working group may present not more than three drafts of legislation implementing potential options.

Subd. 6.

Expiration.

The working group expires upon submission of the proposed legislation required by subdivision 5.

NOT Included in the final tax bill:

- Fifth Tier Income Tax increase
- Corporate Tax Increases, including taxing certain foreign income and a corporate tax rate increase.
- Data center changes
- Resident Trust Language
- Private letter rulings
- Taxation of pre-written computer software

Energy and Commerce Omnibus Bill

Representative Stephenson/Senator Dahms

View the House Research Summary here.

Chapter 4

The Energy and Commerce Omnibus Bill was a combination of two powerful committees, and while it was led by the Commerce Committee, much of the bill was drafted by the Chairs of the House and Senate Energy Committees. The House's bill proposed spending $362.3 million while the Senate proposed spending $355 million. The House emphasized cultivating renewable energy sources, while the Senate focused on extending the state's health reinsurance program and retiring a solar energy incentive program. The agreement was less than both chambers wanted to spend with the final agreement for the biennium at $84 million, $20 million over base spending.

The House bill focused on consumer protection, renewable resources and energy efficiency. The climate and energy portion of the bill would put Minnesota on a path to 100 percent clean energy in the electricity sector by 2030, change energy efficiency goals, and spend money that would support electric vehicle infrastructure. The commerce portion of the bill aimed to reduce drug prices by establishing a Prescription Drug Affordability Board. Additional provisions include a statewide catalytic converter theft prevention program and a cap to payday lending interest rates.

In the Senate, the biggest priority for the Energy and Commerce bill was the extension of the state's health reinsurance program, which supports the Minnesota health insurance market where people under 65 who are self-employed or lack health coverage at their jobs can buy coverage. There was an agreement made by leadership to extend the reinsurance program by one year that will be carried in the HHS bill. The Senate also opted to retire the obligations of the State's solar energy production incentive program, costing $21.2 million.

Notable Provisions and Spending

Commerce

- Increased licensing and regulations for pharmacy benefit managers.
- Student loan borrowers' bill of rights
- Toxic toy enforcement program
- Catalytic converter theft prevention program

NAIC Model Provisions:

Credit for Reinsurance (Article 3- page 14.8)
Insurance Data Security (Act begins on page 25.15)
ANF language (Act begins on page 40.1)

Important NAIC Effective Dates:

- The new ANF interest floor provision is effective June 27, 2021.
- Cybersecurity bill takes effect on August 1, 2021 with the implementation phase-in from the Model for the information security plan requirements
- Credit for reinsurance model takes effect on January 1, 2022.

Department of Commerce funding:

Insurance
Of its $20.6 million in allocations, $12.7 million would go toward operating expenses. Of the remaining money, the largest sums would go toward:

- health insurance rate review, $2 million;
- rate regulation, $1.7 million from the Workers Compensation Fund;
- licensing and regulation of pharmacy benefit managers, $1.3 million; and
- actuarial reserve review, $1.3 million.

Bill Language: Department of Commerce. Appropriates general fund and other fund dollars to the Department of Commerce for specific purposes.

Subd. 1. Total appropriation. Denotes the total amount of money, by fund, appropriated to the Department of Commerce.
Subd. 2. Financial institutions. Appropriates general fund money for financial institutions. Appropriates money for grants to Prepare and Prosper and to administer Minnesota Statutes, chapter 58B.
Subd. 3. Administrative services. Appropriates general fund money for administrative services. Appropriates money for unclaimed property compliance, operations, system modernization, IT modernization, and cybersecurity upgrades, and Real Estate Appraisal Advisory Board compensation
Subd. 5. Enforcement. Appropriates general fund, workers' compensation fund, and consumer education account special revenue fund money. Appropriates money for health care enforcement, catalytic converter theft prevention, and transfers money from the consumer education account to the general fund.
Subd. 6. Insurance. Appropriates general fund and workers' compensation fund money. Appropriates money for health insurance rate review staffing, actuarial work to implement principle-based reserves, dues for the National Conference of Insurance Legislators, licensing pharmacy benefit managers, and to evaluate legislation for new mandated health benefits under Minnesota Statutes, section 62J.26.

Financial institutions

The financial institutions division's $4.3 million allocation includes funding for a securities unit relocation ($2 million) and the Prepare & Prosper free tax preparation program ($1.2 million).

Workers Compensation

Duties of commissioner; Adds information relating to worker's compensation insurers to the report the commissioner provides to the Rate Oversight Commission (loss, trends and loss adjustment).

Mandated Health Benefit Proposals Evaluation

Requirements for evaluation. Requires a legislator who is planning on proposing a bill or amendment that contains a mandated health benefit proposal to notify the chair of the standing legislative committee with jurisdiction over the proposal. Requires the chair of the committee to notify the commissioner that an evaluation is required.

Omnibus Workforce and Jobs Bill

Representative Noor/Senator Pratt
View the House Summary here.
Chapter 10

The Special Session Workforce and Jobs Bill included a General Fund spending target of $171 million for FY22-23, higher than either the House or Senate regular session Jobs bill targets. Of the $171 million General Fund target for next biennium, $150 million is aimed at business relief for firms impacted by COVID and also by civil unrest. The bill also includes a $70 million investment in broadband and $32 million in direct appropriations out of the Workforce Development Fund, mostly to community organizations. The Regular Session House Jobs Bill included Paid Family Medical Leave and Earned Sick and Safe Time which was not included in the final bill. The House will likely make another effort to pass Earned Safe and Sick Time again in 2022.

During the Special Session, the Senate and the House at various points in the process had language requiring additional training for certain workers at petroleum refineries; however, in the end, no refinery training language was included. The bill did contain a provision allowing the manufacturers of commercial chemical dispensing equipment and dishwashing machines to install their equipment without a plumbing license.

Major provisions included in the Jobs Bill are:

- $150 million for business relief:
    - $70 million from the program is targeted to businesses impacted by COVID that have not already received funding. The $70 million divided 50/50 between the metro area and Greater Minnesota.
    - $80 million from the program is for larger economic development
- Minnesota Investment Fund (MIF): Cut of $4.7M in FY22-23 from base of $24.7 million to $20 million. Program returns to base levels in FY24-25. The Governor and House had proposed cuts of $10 million and the Senate had proposed a $2.2 million cut. MIF used declined significantly during the pandemic so it was difficult to justify no cuts for the next biennium.
- Job Creation Fund (JCF): Base funding of $16 million over the biennium maintained.
- Workforce Development Fund Direct Appropriations: $32 million, mostly to community organizations.
- $70 million for Broadband

Legislation of Interest That Did Not Pass

Patient Medical Bill Information Requirements Modification Language
Rep. Elkins/Sen. Draheim: HF 2311/SF2110

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 2020, 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 2020, section 62J.701, is amended to read:

62J.701 GOVERNMENTAL PROGRAMS.

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

~~(c)~~ (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 2020, 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.