State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-THIRD SESSION

H. F. No. 2599

03/06/2023 Authored by Reyer
The bill was read for the first time and referred to the Committee on Health Finance and Policy

A bill for an act

relating to health care; establishing requirements for hospitals to screen patients for eligibility for health coverage or assistance; requiring an affidavit of expert review before certain debt collection activities; limiting hospital charges for uninsured treatments and services for certain patients; proposing coding for new law in Minnesota Statutes, chapter 144.

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

Section 1. **[144.587] REQUIREMENTS FOR SCREENING FOR ELIGIBILITY FOR HEALTH COVERAGE OR ASSISTANCE.**

Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section and sections 144.588 to 144.589.

(b) "Charity care" means the provision of free or discounted care to a patient according to a hospital's financial assistance policies.

(c) "Hospital" means a private, nonprofit, or municipal hospital licensed under sections 144.50 to 144.56.

(d) "Minnesota attorney general/hospital agreement" means the agreement between the attorney general and certain Minnesota hospitals that is filed in Ramsey County District Court and that establishes requirements for hospital litigation practices, garnishments, use of collection agencies, central billing office practices, and practices for billing uninsured patients.

(e) "Most favored insurer" means the nongovernmental third-party payor that provided the most revenue to the provider during the previous calendar year.

(f) "Navigator" has the meaning given in section 62V.02, subdivision 9.

(g) "Premium tax credit" means a tax credit or premium subsidy under the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to and federal guidance and regulations issued under these acts.

(h) "Presumptive eligibility" has the meaning given in section 256B.057, subdivision 12.

(i) "Revenue recapture" means the use of the procedures in chapter 270A to collect debt.

(j) "Uninsured service or treatment" means any service or treatment that is not covered by: (1) a health plan, contract, or policy that provides health coverage to a patient; or (2) any other type of insurance coverage, including but not limited to no-fault automobile coverage, workers' compensation coverage, or liability coverage.

(k) "Unreasonable burden" includes requiring a patient to apply for enrollment in a state or federal program for which the patient is obviously or categorically ineligible or has been found to be ineligible in the previous 12 months.

Subd. 2. **Screening.** A hospital must screen a patient who is uninsured or whose insurance coverage status is not known by the hospital for: eligibility for charity care from the hospital; eligibility for state or federal public health care programs using presumptive eligibility or another similar process; and eligibility for a premium tax credit. The hospital must attempt to complete this screening process in person or by telephone within 30 days after the patient receives services at the hospital or at the emergency department associated with the hospital.

Subd. 3. **Charity care.** (a) Upon completion of the screening process in subdivision 2, the hospital must either assist the patient with applying for charity care and refer the patient to the appropriate department in the hospital for follow-up or make a determination that the patient is ineligible for charity care. A hospital may initiate one or more of the following steps only after the hospital determines that the patient is ineligible for charity care and may not initiate any of the following steps while the patient's application for charity care is pending:

(1) offering to enroll or enrolling the patient in a payment plan;

(2) changing the terms of a patient's payment plan;

(3) offering the patient a loan or line of credit, application materials for a loan or line of credit, or assistance with applying for a loan or line of credit, for the payment of medical debt;

(4) referring a patient's debt for collections, including in-house collections, third-party collections, revenue recapture, or any other process for the collection of debt;

(5) denying health care services to the patient or any member of the patient's household because of outstanding medical debt, regardless of whether the services are deemed necessary or may be available from another provider; or

(6) accepting a credit card payment of over $500 for the medical debt owed to the hospital.

(b) A hospital may not impose application procedures for charity care that place an unreasonable burden on the individual patient, taking into account the individual patient's physical, mental, intellectual, or sensory deficiencies or language barriers that may hinder the patient's ability to comply with application procedures.

(c) When a hospital evaluates a patient's eligibility for charity care, hospital requests to the responsible party for verification of assets or income shall be limited to:

(1) information that is reasonably necessary and readily available to determine eligibility; and

(2) facts that are relevant to determine eligibility.

A hospital must not demand duplicate forms of verification of assets.

Subd. 4. **Public health care program; premium tax credit.** (a) If a patient is presumptively eligible for a public health care program, the hospital must assist the patient in completing an insurance affordability program application, help the patient schedule an appointment with a navigator organization, or provide the patient with contact information for the nearest available navigator services.

(b) If a patient is eligible for a premium tax credit, the hospital may schedule an appointment for the patient with a navigator organization or provide the patient with contact information for the nearest available navigator services.

Subd. 5. **Patient may decline services.** A patient may decline to participate in the screening process, to apply for charity care, to complete an insurance affordability program application, to schedule an appointment with a navigator organization, or to accept information about navigator services.

Subd. 6. **Notice.** (a) A hospital must post notice of the availability of charity care from the hospital in at least the following locations: (1) areas of the hospital where patients are admitted or registered; (2) emergency departments; and (3) the portion of the hospital's financial services or billing department that is accessible to patients. The posted notice must

be in all languages spoken by more than five percent of the population in the hospital's service area.

(b) A hospital must make available on the hospital's website, the current version of the hospital's charity care policy, a plain-language summary of the policy, and the hospital's charity care application form. The summary and application form must be available in all languages spoken by more than five percent of the population in the hospital's service area.

EFFECTIVE DATE. This section is effective November 1, 2023.

Sec. 2. **[144.588] CERTIFICATION OF EXPERT REVIEW.**

Subdivision 1. **Requirement; action to collect medical debt or garnish wages or bank accounts.** (a) In an action against a patient for collection of medical debt owed to a hospital or for garnishment of the patient's wages or bank accounts to collect medical debt owed to a hospital, the hospital must serve on the defendant with the summons and complaint an affidavit of expert review certifying that the hospital:

(1) made all of the verifications required of the hospital in the most recent version of the Minnesota attorney general/hospital agreement in order to collect the specific patient's debt or to garnish the specific patient's wages or bank accounts; and

(2) unless the patient declined to participate, complied with the requirements in section 144.587 to conduct a patient screening and, as applicable, assist the patient in applying for charity care, assist the patient with completing an insurance affordability program application, or refer the patient to a navigator organization.

(b) The affidavit of expert review must be completed by a designated employee of the hospital seeking to initiate the action or garnishment.

Subd. 2. **Requirement; referral to third-party debt collection agency.** (a) In order to refer a patient's account to a third-party debt collection agency, a hospital must complete an affidavit of expert review certifying that the hospital:

(1) confirmed the information required of the hospital in the most recent version of the Minnesota attorney general/hospital agreement for referral of a specific patient's account to a third-party debt collection agency; and

(2) unless the patient declined to participate, complied with the requirements in section 144.587 to conduct a patient screening and, as applicable, assist the patient in applying for charity care, assist the patient with completing an insurance affordability program application, or refer the patient to a navigator organization.

(b) The affidavit of expert review must be completed by a designated employee of the hospital seeking to refer the patient's account to a third-party debt collection agency.

Subd. 3. **Penalty for noncompliance.** Failure to comply with subdivision 1 shall result, upon motion, in mandatory dismissal with prejudice of the action to collect the medical debt or to garnish the patient's wages or bank accounts. Failure to comply with subdivision 2 shall subject a hospital to a fine assessed by the commissioner of health.

EFFECTIVE DATE. This section is effective November 1, 2023.

Sec. 3. **[144.589] BILLING OF UNINSURED PATIENTS.**

A hospital shall not charge a patient whose annual household income is less than $125,000 for any uninsured service or treatment in an amount that exceeds the total amount the provider would be reimbursed for that service or treatment from its most favored insurer. The total amount the provider would be reimbursed for that service or treatment from its most favored insurer includes both the amount the provider would be reimbursed directly from its most favored insurer, and the amount the provider would be reimbursed from the insured's policyholder under any applicable co-payments, deductibles, and coinsurance.

EFFECTIVE DATE. This section is effective November 1, 2023.