State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-SECOND SESSION

H. F. No. 57

01/11/2021 Authored by Elkins
The bill was read for the first time and referred to the Committee on Commerce Finance and Policy

A bill for an act

relating to health; requiring medical practices to make available to the public their current standard charges; authorizing the commissioner of health to establish a price comparison tool for items and services offered by medical practices; proposing coding for new law in Minnesota Statutes, chapter 62J.

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

Section 1. **[62J.826] MEDICAL PRACTICES; CURRENT STANDARD CHARGES; COMPARISON TOOL.**

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Chargemaster" means the list of all individual items and services maintained by a medical practice for which the medical practice has established a charge.

(c) "Diagnostic laboratory testing" means a service charged using a CPT code within the CPT code range of 80047 to 89398.

(d) "Diagnostic radiology service" means a service charged using a CPT code within the CPT code range of 70010 to 7999 and includes the provision of x-rays, computed tomography scans, positron emission tomography scans, magnetic resonance imaging scans, and mammographies.

(e) "Hospital" means an acute care institution licensed under sections 144.50 to 144.58, but does not include a health care institution conducted for those who rely primarily upon treatment by prayer or spiritual means in accordance with the creed or tenets of any church or denomination.

(f) "Medical practice" means a business that:

(1) earns revenue by providing medical care to the public;

(2) issues payment claims to health plan companies and other payers; and

(3) may be identified by its federal tax identification number.

(g) "Outpatient surgical center" means a health care facility other than a hospital offering elective outpatient surgery under a license issued under sections 144.50 to 144.58.

Subd. 2. **Requirement; current standard charges.** The following medical practices must make available to the public a list of their current standard charges, as reflected in the medical practice's chargemaster, for all items and services provided by the medical practice:

(1) hospitals;

(2) outpatient surgical centers; and

(3) any other medical practice that has revenue of greater than $50,000,000 per year and that derives the majority of its revenue by providing one or more of the following services:

(i) diagnostic radiology services;

(ii) diagnostic laboratory testing;

(iii) orthopedic surgical procedures, including joint arthroplasty procedures within the CPT code range of 26990 to 27899;

(iv) opthalmologic surgical procedures, including cataract surgery coded using CPT code 66982 or 66984, or refractive correction surgery to improve visual acuity;

(v) anesthesia services commonly provided as an ancillary to services provided at a hospital, outpatient surgical center, or medical practice that provides orthopedic surgical procedures or opthalmologic surgical procedures; or

(vi) oncology services, including radiation oncology treatments within the CPT code range of 77261 to 77799 and drug infusions.

Subd. 3. **Required file format and data attributes.** (a) A medical practice required to post its current standard charges must post the following data attributes in the listed order:

(1) federal tax identification number for the medical practice;

(2) name of the medical practice, defined as the provider name that the medical practice enters on the CMS claim form 1500 or a successor form when it submits health care claims to a payer organization;

(3) internal chargemaster record identification, defined as the internal record identifier for this chargemaster line item in the medical practice's billing system;

(4) service billing code system, defined as a code signifying the HIPAA-compliant billing code system from which the service billing code was drawn;

(5) service billing code, defined as a specific billing code drawn from the service billing code system denoted by the value in the service billing code type field;

(6) service description, defined as the shortest, nonabbreviated official description associated with the service billing code in the applicable service billing code system;

(7) revenue code, defined as the National Uniform Billing Committee revenue code denoting the patient's location within the medical practice where the patient will receive the item or service subject to this charge. This value is required only if the charge amount is dependent on the location within the medical practice where the item or service is provided;

(8) revenue code description, defined as the description provided by the National Uniform Billing Committee for the revenue code. This value is required only if the charge amount is dependent on the location within the medical practice where the item or service is provided;

(9) national drug code, defined as the national drug code for a drug that is administered as part of the service subject to this charge. This field is required only when the charge amount is dependent on which, if any, drug is being administered as part of this service;

(10) national drug code description, defined as the official description associated with the national drug code for a drug that is administered as part of the service subject to this charge. This field is required only when the charge amount is dependent on which, if any, drug is being administered as part of this service;

(11) inpatient gross charge, defined as the charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts as defined in Code of Federal Regulations, title 45, section 180.20, for an item or service provided on an inpatient basis;

(12) outpatient gross charge, defined as the charge for an individual item or service that is reflected on a chargemaster, absent any discounts as defined in Code of Federal Regulations, title 45, section 180.20, for an item or service provided on an outpatient basis;

(13) inpatient discounted cash price, defined as the charge that applies to an individual who pays cash or a cash equivalent for an item or service being reported under this section and provided on an inpatient basis;

(14) outpatient discounted cash price, defined as the charge that applies to an individual who pays cash or a cash equivalent for an item or service being reported under this section and provided on an outpatient basis;

(15) charge unit, defined as the unit cost basis for the charge; and

(16) effective date of the charge.

(b) The data attributes specified in paragraph (a) must be posted in the form of a comma separated values file.

(c) The data attributes specified in paragraph (a) must be reported to the commissioner of health in a form, manner, and frequency specified by the commissioner, and must be made available to the public in a form and manner specified by the commissioner.

Subd. 4. **Price comparison tool.** The commissioner may use the information reported to the commissioner under subdivision 3 to develop and make available to the public, a tool for the public to use to compare charges for a specific item or service across medical practices that offer that item or service. The commissioner may contract with a third party for the development and operation of the tool for the public to use to compare charges for that item or service.

EFFECTIVE DATE. This section is effective the day following final enactment.