SENATE
STATE OF MINNESOTA
NINETY-FIRST SESSION

S.F. No. 4209

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DATE	D-PG	OFFICIAL STATUS
03/09/2020		Introduction and first reading
		Referred to Health and Human Services Finance and Policy

A bill for an act

relating to health; determining payment parameters for emergency services; amending Minnesota Statutes 2018, section 62Q.556.

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

Section 1. Minnesota Statutes 2018, section 62Q.556, is amended to read:

62Q.556 UNAUTHORIZED PROVIDER SERVICES.

Subdivision 1. **Unauthorized provider services.** ~~(a) Except as provided in paragraph (c),~~ Unauthorized provider services occur when an enrollee receives ~~services~~:

(1) emergency services as defined under section 62Q.55, subdivision 3, from a nonparticipating provider, hospital, or other facility;

~~(1)~~ (2) services from a nonparticipating provider at a participating hospital or ambulatory surgical center~~, when the services are rendered:~~; or

~~(i) due to the unavailability of a participating provider;~~

~~(ii) by a nonparticipating provider without the enrollee's knowledge; or~~

~~(iii) due to the need for unforeseen services arising at the time the services are being rendered; or~~

~~(2)~~ (3) services from a participating provider that sends a specimen taken from the enrollee in the participating provider's practice setting to a nonparticipating laboratory, pathologist, or other medical testing facility.

~~(b) Unauthorized provider services do not include emergency services as defined in section 62Q.55, subdivision 3.~~

~~(c) The services described in paragraph (a), clause (2), are not unauthorized provider services if the enrollee gives advance written consent to the provider acknowledging that the use of a provider, or the services to be rendered, may result in costs not covered by the health plan.~~

Subd. 2. **Prohibition.** (a) An enrollee's financial responsibility for the unauthorized provider services shall be the same cost-sharing requirements, including co-payments, deductibles, coinsurance, coverage restrictions, and coverage limitations, as those applicable to services received by the enrollee from a participating provider. A health plan company must apply any enrollee cost sharing requirements, including co-payments, deductibles, and coinsurance, for unauthorized provider services to the enrollee's annual out-of-pocket limit to the same extent payments to a participating provider would be applied.

(b) A provider, hospital, laboratory, or other facility shall not bill the enrollee for unauthorized provider services for an amount greater than the enrollee's financial responsibility as determined under paragraph (a).

~~(b)~~ (c) A health plan company must attempt to negotiate the reimbursement, less any applicable enrollee cost sharing under paragraph (a), for the unauthorized provider services with the nonparticipating provider. If a health plan company's and nonparticipating provider's attempts to negotiate reimbursement for the health care services do not result in a resolution, the health plan company or provider may elect to refer the matter for binding arbitration, chosen in accordance with paragraph ~~(c)~~ (d). A nondisclosure agreement must be executed by both parties prior to engaging an arbitrator in accordance with this section. The cost of arbitration must be shared equally between the parties.

~~(c)~~ (d) The ~~commissioner~~ commissioners of health and commerce, in consultation with the commissioner of the Bureau of Mediation Services, must develop a list of professionals qualified in arbitration, for the purpose of resolving disputes between a health plan company and nonparticipating provider arising from the payment for unauthorized provider services. The commissioner of health shall publish the list on the Department of Health website, and update the list as appropriate.

~~(d)~~ (e) The arbitrator must consider relevant information, including the health plan company's payments to other nonparticipating providers for the same services, the circumstances and complexity of the particular case, and the usual and customary rate for the service based on information available in a database in a national, independent, not-for-profit corporation, and similar fees received by the provider for the same services from other health plans in which the provider is nonparticipating, in reaching a decision.

Subd. 3. **Annual data reporting.** (a) Beginning April 1, 2021, a health plan company must report annually to the commissioner:

(1) the total number of claims and total billed and paid amount for unauthorized provider services, by service and provider type, submitted to the health plan in the prior calendar year;

(2) the total number of claims and total billed and paid amount for unauthorized provider services, by service and provider type, submitted for binding arbitration pursuant to subdivision 2, paragraph (c), in the prior calendar year; and

(3) the total number of enrollee complaints received regarding unauthorized provider services in the prior calendar year.

(b) The commissioners of commerce and health may develop a format for health plan companies to comply with paragraph (a).

Subd. 4. **Enforcement.** (a) Any provider licensed under chapter 144 or 147 is subject to the requirements of this section.

(b) The commissioner of commerce or health may enforce this section. If the commissioner of health has cause to believe that any hospital or facility licensed under chapter 144 has violated this section, the commissioner may investigate, examine, and otherwise enforce this section pursuant to chapter 144 or may refer the potential violation to the relevant licensing board with regulatory authority over the provider.

(c) If the Minnesota Board of Medical Practice has cause to believe that a provider has violated this section it may further investigate and enforce the provisions of this section pursuant to chapter 214.