# HOUSE RESEARCH

## Bill Summary

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**Subject:** Health coverage market reform

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## Overview

This bill makes a variety of changes in laws affecting health care and health coverage.

**Section**

**1** **Authorized entity.** Creates this new term defining the type of entity that may become a licensed health maintenance organization (HMO). "Authorized entity" includes a for-profit or nonprofit corporation, a limited liability company, or a local government. A corporation or limited liability company may be organized under the laws of a state other than Minnesota. Current law permits only nonprofit corporations and local governments.

**2** **Health maintenance organization.** Amends the definition of an HMO to conform to section 1.

**3** **Certificate of authority required.** Changes the licensing requirement for HMOs to permit licensure of any type of "authorized entity," as defined in section 1. Requires that an out-of-state corporation or out-of-state limited liability company must register with the state on the same basis generally required of out-of-state companies doing business in the state.

**4** **Authority granted.** A conforming change to sections 1 to 3.

**5** **Provider cost disclosure.** Amends the health care provider price disclosure law enacted in 2005 to make the exemption for hospitals and outpatient surgical centers depend upon their being subject to the disclosure requirements of the following section, increase the number of services covered from 20 to 50, and add a new identical price disclosure provision for pharmacies.

**6** **Hospital pricing transparency.** This section is called the "hospital pricing transparency

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act." Requires hospital and outpatient surgery centers to provide a written estimate of the cost of a specific service or stay upon request to a patient, doctor, or patient's representative. Permits the estimate to be arrived at in a variety of ways. Specifies what information must be included in the request for the estimate. Specifies the information that must be included in the estimate. Permits the estimate to be provided in any way that meets the needs of both sides, including electronically, but requires a paper copy be provided if requested.

**7** **Required disclosure of estimated payment.** Amends a law enacted in 2004 that requires health care providers to disclose to a consumer the amount of payment the provider expects from the consumer's health plan company. This section permits the disclosure to be made by the provider's designee and also requires the health plan company to give an enrollee a good faith estimate of what the health plan company would expect to pay a specified provider for a health care service specified by the enrollee. Provides that the estimate is not binding on the health plan company.

**8** **Provider pricing fairness.** Prohibits health care providers from varying the amount they will accept as full payment for a health care service based upon the identity of the payer, upon a contract between the payer and provider, upon the identity of the patient, or upon whether the patient is covered by a "group purchaser," as that term is defined in existing law. Provides that the law does not apply when the payer is a government. Provides that this section does not affect the provider's right to provide charity care or reduced price care to a friend or relative.

**9** **Small health plan purchasing pool.** (a) Permits health plan companies that have a small share of the Minnesota market to form a purchasing pool to jointly negotiate contracts for health care purchases from providers. Participation by a health plan company would be voluntary.

(b) Permits members of the purchasing pool to use those contracts to provide health care to their enrollees.

(c) Permits the providers to use those contracts in connection with discount cards they could sell to persons who have no private or public sector health coverage. The discounts available through the discount cards need not be the same as those used under paragraph (b) to cover the company's enrollees. Requires the discount cards and related advertising to say that the cards are not insurance or HMO coverage and that holders of the cards need to check with providers to find out if they honor the cards.

(d) Requires the commissioner of commerce to supervise this purchasing pool to ensure that it promotes competition by allowing these smaller health plan companies to better compete with their larger competitors.

**10** **Health insurance.** Creates a new definition of "health insurance" for purposes of the following section. This new definition includes health plans offered by all health plan companies (for-profit and nonprofit) and stop-loss insurance coverage on self-insured health plans. It does not exclude fraternal benefit societies, but they are exempt from premium taxes under another statute. It uses a broad definition of health plan that includes dental and vision care, long-term care insurance, Medicare supplement insurance, and insurance policies issued as a companion to HMO contracts (usually to provide out-of-network coverage).

**11** **Health insurance.** (a) This section amends the premium tax on health coverage, using the

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definition provided in the preceding section. Currently, for-profit insurance companies pay a 2 percent premiums tax, while nonprofit health plan companies (HMOs and Blue Cross) pay a 1 percent premiums tax. This section moves the health insurance part of the for-profit insurers' business into the same tax now paid by the nonprofits. The tax rate to be used on this combined health coverage category is left blank in the bill, presumably to be set at the rate between 1 and 2 percent that would make this change revenue neutral for the state. Provides that the tax imposed in this section is in lieu of any other tax that could apply under any other subdivision of this section of the tax laws, except for the retaliatory taxes. That sentence exempts health insurance provided by for-profit insurers from the 2 percent tax to which it is now subjected.

(b) Provides that the revenues from the newly merged tax goes into the health care access fund. The current 1 percent tax on non-profit health plan companies goes into the health care access fund, and the current 2 percent premiums tax on for-profit insurers goes into the general fund.

**12** **Repealer.** (a) Repeals the law enacted in 1992 requiring that health care providers report "major spending commitments" to the commissioner of health for retrospective review, or in some cases, prospective review and prior approval. This applies to certain spending commitments in excess of $1,000,000. The repealer is effective immediately.

(b) Repeals the "mandatory Medicare assignment" law enacted in 1992, which prohibits health care providers from "balance billing" Medicare patients for any amount in excess of the Medicare approved amount. Federal law permits balance-billing patients for up to 15 percent of the Medicare approved amount. The repealer is effective for care provided on or after January 1, 2007.