Senator ..... moves to amend S.F. No. 2673 as follows:

Delete everything after the enacting clause and insert:

"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) "Insurance affordability program" has the meaning given in section 256B.02, subdivision 19.

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

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

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

(h) "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.

(i) "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) A hospital participating in the hospital presumptive eligibility program under section 256B.057, subdivision 12, must determine whether a patient who is uninsured or whose insurance coverage status is not known by the hospital is eligible for hospital presumptive eligibility coverage.

(b) For any uninsured patient, including any patient the hospital determines is eligible for hospital presumptive eligibility coverage, and for any patient whose insurance coverage status is not known to the hospital, a hospital must:

(1) if it is a certified application counselor organization, schedule an appointment for the patient with a certified application counselor to occur prior to discharge;

(2) if it is not a certified application counselor organization, schedule prior to discharge an appointment for the patient with a MNsure-certified navigator to occur after discharge; or

(3) if the patient declines the scheduling of an appointment under clause (1) or (2), provide the patient with contact information for available MNsure-certified navigators who can meet the needs of the patient.

(c) For any uninsured patient, including any patient the hospital determines is eligible for hospital presumptive eligibility coverage, and any patient whose insurance coverage status is not known to the hospital, a hospital must screen the patient for eligibility for charity care from the hospital. The hospital must attempt to complete the screening process for charity care 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, paragraph (c), the hospital must determine whether the patient is eligible for charity care. 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.

(b) If the patient is eligible for charity care, the hospital must assist the patient with applying for charity care and refer the patient to the appropriate department in the hospital for follow-up. 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) A hospital may not initiate any of the actions described in subdivision 4 while the patient's application for charity care is pending.

Subd. 4. **Prohibited actions.** A hospital must not initiate one or more of the following actions until the hospital determines that the patient is ineligible for charity care or denies an application for charity care:

(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.

Subd. 5. **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.

Subd. 6. **Patient may decline services.** A patient may decline to complete an insurance affordability program application to schedule an appointment with a certified application counselor, to schedule an appointment with a MNsure-certified navigator, to accept information about navigator services, to participate in the charity care screening process, or to apply for charity care.

Subd. 7. **Enforcement.** In addition to the enforcement of this section by the commissioner, the attorney general may enforce this section under section 8.31.

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:

(1) unless the patient declined to participate, the hospital complied with the requirements in section 144.587;

(2) there is a reasonable basis to believe that the patient owes the debt;

(3) all known third-party payors have been properly billed by the hospital, such that any remaining debt is the financial responsibility of the patient, and the hospital will not bill the patient for any amount that an insurance company is obligated to pay;

(4) the patient has been given a reasonable opportunity to apply for charity care, if the facts and circumstances suggest that the patient may be eligible for charity care;

(5) where the patient has indicated an inability to pay the full amount of the debt in one payment and provided reasonable verification of the inability to pay the full amount of the debt in one payment if requested by the hospital, the hospital has offered the patient a reasonable payment plan;

(6) there is no reasonable basis to believe that the patient's wages or funds at a financial institution are likely to be exempt from garnishment; and

(7) in the case of a default judgment proceeding, that there is not a reasonable basis to believe:

(i) that the patient may already consider that he or she has adequately answered the complaint by calling or writing to the hospital, its debt collection agency, or its attorney;

(ii) that the patient is sick, disabled, infirm, or so elderly so as to potentially render the patient unable to answer the complaint; or

(iii) the patient may not have received service of the complaint.

(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:

(1) unless the patient declined to participate, the hospital complied with the requirements in section 144.587;

(2) there is a reasonable basis to believe that the patient owes the debt;

(3) all known third-party payors have been properly billed by the hospital, such that any remaining debt is the financial responsibility of the patient, and the hospital will not bill the patient for any amount that an insurance company is obligated to pay;

(4) the patient has been given a reasonable opportunity to apply for charity care, if the facts and circumstances suggest that the patient may be eligible for charity care; and

(5) where the patient has indicated an inability to pay the full amount of the debt in one payment and provided reasonable verification of the inability to pay the full amount of the debt in one payment if requested by the hospital, the hospital has offered the patient a reasonable payment plan.

(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. In addition to the enforcement of this section by the commissioner, the attorney general may enforce this section under section 8.31.

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

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

Subdivision 1. **Limits on charges.** A hospital must 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 lowest total amount the provider would be reimbursed for that service or treatment from a private insurer. The lowest total amount the provider would be reimbursed for that service or treatment from a private insurer includes both the amount the provider would be reimbursed directly from the private insurer and the amount the provider would be reimbursed from the insured's policyholder under any applicable co-payments, deductibles, and coinsurance.

Subd. 2. **Enforcement.** In addition to the enforcement of this section by the commissioner, the attorney general may enforce this section under section 8.31.

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

Amend the title accordingly