



# Minnesota's Price Transparency Laws

## 2004

**Provider price disclosure ([Minnesota Statute 62J.81](#)):** Health care providers were mandated at the request of a consumer to provide the consumer with a good faith estimate of the reimbursement the provider expects to receive from the health plan company in which the consumer is enrolled. Health plan companies must allow contracted providers to release this information. A good faith estimate must also be made available at the request of a consumer who is not enrolled in a health plan.

## 2005

**Hospital charge disclosure ([Minnesota Statute 62J.82](#)):** The Minnesota Hospital Association is directed to establish a web-based system for reporting hospital charges for Minnesota residents. Reporting must include number of discharges, average length of stay, average charge, average charge per day, and median charge for each of the 50 most common inpatient diagnosis-related-groups and 25 most common outpatient surgical procedures. *(MHA now includes on our website charge information for all inpatient procedures.)*

**Provider charge disclosure ([Minnesota Statute 62J.052, Subd. 1](#) – repealed in 2007):** All health providers except hospitals and outpatient surgery centers annually must make available the following information: 1) average allowable payment from private third-party payers for the 20 services or procedures most commonly provided; 2) average MA payment rate for those procedures; 3) the average charge for those services for clients who have no coverage; 4) the average charge for all patients. The information must be available on site at no cost to the public.

## 2006

**Health plan company transparency ([Minnesota Statute 62J.81, Subd. 1a.](#)):** Health plan companies, at the request of an enrollee or an enrollee's designee, must provide good faith estimates of the reimbursement the health plan company would expect to pay to a specified provider within the network for a health care service specified by an enrollee. Enrollees can also request of their health plan company a good faith estimate of an enrollee's out-of-pocket cost for the health care service.

**Hospital pricing transparency ([Minnesota Statute 62J.823](#)):** This law required hospitals to provide patients with an estimate of the actual price expected to be billed to the individual or to their health plan company based upon a specific procedure or diagnostic related group (DRG) code and reflecting any known discounts. The patient must tell the hospital the name of their specific health plan as well as any information such as a DRG, procedure code, or type of treatment to be received, which helps the hospital or outpatient surgical center to determine the cost of a specific service. The 2006 law clarifies the 2004 law, that a consumer can also obtain the charge and discount information as well as expected payment information.

## 2017

**Surprise billing law ([Minnesota Statute 62Q.556](#)):** The 2017 Health Care Emergency Aid and Access Act included new language to help prevent surprise billing. The law requires that patients be held harmless while requiring a health plan and non-participating provider to negotiate payment. If a payment agreement cannot be reached between the health plan company and the nonparticipating provider, either party may elect to refer the matter to binding arbitration. The original effective date was April 26, 2017, but the implementation was delayed in subsequent legislation until Jan. 1, 2018.

## 2018

**Provision of good faith price estimates ([Minnesota Statute 62J.824](#)):** In addition to the good faith estimates previously imposed in Minnesota law, health care providers must also provide information on other types of fees or charges that a consumer may be required to pay in conjunction with a visit, including but not limited to applicable facility fees. In addition, the health care provider and health plan company must now provide price information to the consumer or enrollee within 10 business days from the complete request being received. No contract between a health care provider and health plan company can prohibit the disclosure of pricing information required under this section. This became effective on July 1, 2019.

**Primary care price transparency ([Minnesota Statute 62J.812](#)):** This law requires primary care providers and clinics that specialize in family medicine, general internal medicine, gynecology, or general pediatrics to maintain and post a list of the 25 most frequently billed services over \$25, including the 10 most commonly billed evaluation and management services, and of the 10 most frequently billed preventive services. A health system may develop one list to use for all its associated primary care providers and clinics. For each service, the provider or clinic must disclose:

- Provider's charge, the amount charged to an uninsured patient;
- Average commercial health plan payment rate;
- Medicare payment rate; and
- Medical Assistance fee-for-service rate.

The list must be updated annually and posted in the provider or clinic's reception area and made available on the provider's website, if a website is maintained. No contract between a health care provider and health plan company can prohibit the disclosure of the pricing information required under this section. This became effective on July 1, 2019.

## 2019

**Provider network notification ([Minnesota Statute 62K.075](#)):** Health plan companies are required to provide on their websites the provider network for each product and to update the website at least once a month. The law requires health plan companies to provide on the website the current waivers of the network geographic accessibility standard.

**Disclosure of hospital charges ([Minnesota Statute 144.591](#)):** Hospitals are mandated to provide to each discharged patient within 30 calendar days of discharge an itemized description of billed charges for medical services and goods the patient received during the hospital stay. The itemized description of billed charges may include technical terms to describe the medical services and goods if the technical terms are defined on the itemized description with limited medical nomenclature. A hospital may not bill or otherwise charge a patient for the itemized description of billed charges. This section does not apply to patients enrolled in Medicare, Medical Assistance, the MinnesotaCare program, or who receive health care coverage through an employer self-insured health plan. This law had an original effective date of Aug. 1, 2020. A subsequent law delayed the effective date to Jan. 1, 2021.

**Provider-based clinic facility fee disclosure ([Minnesota Statute 62J.824](#)):** Prior to the delivery of non-emergency services, a provider-based clinic that charges a facility fee shall provide notice to any patient stating that the clinic is part of a hospital and the patient may receive a separate charge or billing for the facility component, which may result in a higher-out-of-pocket expense. Each health care facility must post prominently in locations easily accessible to and visible by patients, including its website, a statement that the provider-based clinic is part of a hospital, and the patient may receive a separate charge or billing for the facility, which may result in a higher out-of-pocket expense. This law was effective Aug. 1, 2019.

## Federal Requirements

New federal rules for price transparency went into effect on Jan. 1, 2021. Below is a high-level overview of the significant amount of information that is required to be posted.

### Five types of “Standard Charges” in a Machine Readable File ([45 CFR §180.50](#)):

- Gross charge: The charge for an individual item or service that is reflected on a hospital’s chargemaster, absent any discounts.
- Discounted cash price: The charge that applies to an individual who pays cash, or cash equivalent, for a hospital item or service.
- Payer-specific negotiated charge: The charge that a hospital has negotiated with a third-party payer for an item or service.
- De-identified minimum negotiated charges: The lowest charge that a hospital has negotiated with all third-party payers for an item or service.
- De-identified maximum negotiated charges: The highest charge that a hospital has negotiated with all third-party payers for an item or service.

### A requirement to publicly display a list of 300 “shoppable services” ([45 CFR §180.60](#)):

- Provide standard charges and payer-specific negotiated charges for each service
  - CMS provides 70 ‘starter’ services.
  - *(Hospitals that have an online estimator tool are exempt from this section as long as the tool is available to the public and meets the requirements of this section to report 300 shoppable services.)*
- For each shoppable service displayed, the hospital must:
  - Include a plain-language description.
  - Group the primary shoppable service with the ancillary services typically associated with the service.
  - Indicate the location at which the shoppable service is provided (hospital, inpatient, outpatient, clinic, etc.)

### No Surprises Act, 2020 ([45 CFR § 149.410 – 149.450](#))

On Dec. 27, 2020, Congress enacted the No Surprises Act as a part of the Consolidated Appropriations Act of 2021, providing new federal consumer protections against surprise medical bills. The measure was included in omnibus legislation funding the federal government for fiscal year 2021 and providing stimulus relief for the COVID-19 pandemic. The new law took effect for health plan years beginning on or after Jan. 1, 2022, and it applies to nearly all private health plans offered by employers, as well as non-group individual plans. The law:

- Prohibits out-of-network providers from balance billing patients beyond the in-network cost sharing amounts.
- Establishes an independent dispute resolution process to determine out-of-network payment amounts between providers and health plans.
- Requires good faith estimates of medical items or services for uninsured or self-pay individuals.
- Establishes a patient-provider dispute process for uninsured or self-pay individuals to determine payment amounts.
- Requires providers to publicly post disclosures of patient protections against balance billing.