

Minnesota's Transparency in Pricing Requirements

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By way of Mark Fisher, and the MNGMA Government Affairs Committee*

During 2006, Minnesota's legislature established transparency requirements affecting all providers, including physicians, surgeons, hospitals, clinics, and so forth...and health plans.

National health care reform leaders have told us that these are, perhaps, the most aggressive and comprehensive of transparency laws in the country.

These regard requiring providers and health plans to disclose their prices, an essential element of the transparency necessary to make HDHPs, and HSAs work.

I. Requirements for providers (except hospitals and outpatient surgical centers)

62J.052 PROVIDER COST DISCLOSURE.

Subdivision 1. **Health care providers.** (a) Each health care provider, as defined by section [62J.03, subdivision 8](#), except hospitals and outpatient surgical centers subject to the requirements of section [62J.823](#), shall provide the following information:

- (1) the average allowable payment from private third-party payers for the 50 services or procedures most commonly performed;
- (2) the average payment rates for those services and procedures for medical assistance;
- (3) the average charge for those services and procedures for individuals who have no applicable private or public coverage; and
- (4) the average charge for those services and procedures, including all patients.

(b) This information shall be updated annually and be readily available at no cost to the public on site.

Effective Date: October 1, 2006

II Additional disclosure requirements for providers and new requirements for health plans

We noted with special interest the requirement for a "good faith estimate" as in Subd. 1, (a) below. Like going to an auto repair shop and getting a fixit estimate before you begin.

62J.81 DISCLOSURE OF PAYMENTS FOR HEALTH CARE SERVICES.

Subdivision 1. **Required disclosure of estimated payment.** (a) A health care provider, as defined in section [62J.03, subdivision 8](#), or the provider's designee as agreed to by that designee, shall, at the request of a consumer, provide that 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, or their designee, 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 company. Payment information provided by a provider, or by the provider's designee as agreed to by that designee, to a patient pursuant to this subdivision does not constitute a legally binding estimate of the cost of services.

(b) A health plan company, as defined in section [62J.03, subdivision 10](#), shall, at the request of an enrollee or the enrollee's designee, provide that enrollee with a good faith estimate 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 the enrollee. If requested by the enrollee, the health plan company shall also provide to the enrollee a good faith estimate of the enrollee's out-of-pocket cost for the health care service. An estimate provided to an enrollee under this paragraph is not a legally binding estimate of the reimbursement or out-of-pocket cost.

Subd. 2. **Applicability.** For purposes of this section, "consumer" does not include a medical assistance, MinnesotaCare, or general assistance medical care enrollee, for services covered under those programs.

History: 2004 c 288 art 7 s 3; 2006 c 255 s 24

Effective Dates: Paragraph (a) was effective the day following final enactment. Paragraph (b) was effective January 1, 2007

III. Requirements for hospitals and outpatient surgical centers

62J.823 HOSPITAL PRICING TRANSPARENCY.

Subdivision 1. **Short title.** This section may be cited as the Hospital Pricing Transparency Act.

Subd. 2. **Definition.** For the purposes of this section, "estimate" means the actual price expected to be billed to the individual or to the individual's health plan company based on the specific diagnostic-related group code or specific procedure code or codes, reflecting any known discounts the individual would receive.

Subd. 3. **Applicability and scope.** Any hospital, as defined in section [144.696](#), subdivision 3, and outpatient surgical center, as defined in section [144.696, subdivision 4](#), shall provide a written estimate of the cost of a specific service or stay upon the request of a patient, doctor, or the patient's representative. The request must include:

- (1) the health coverage status of the patient, including the specific health plan or other health coverage under which the patient is enrolled, if any; and
- (2) at least one of the following:
 - (i) the specific diagnostic-related group code;
 - (ii) the name of the procedure or procedures to be performed;
 - (iii) the type of treatment to be received; or
 - (iv) any other information that will allow the hospital or outpatient surgical center to determine the specific diagnostic-related group or procedure code or codes.

Subd. 4. **Estimate.** (a) An estimate provided by the hospital or outpatient surgical center must contain:

- (1) the method used to calculate the estimate;
 - (2) the specific diagnostic-related group or procedure code or codes used to calculate the estimate, and a description of the diagnostic-related group or procedure code or codes that is reasonably understandable to a patient; and
 - (3) a statement indicating that the estimate, while accurate, may not reflect the actual billed charges and that the final bill may be higher or lower depending on the patient's specific circumstances.
- (b) The estimate may be provided in any method that meets the needs of the patient and the hospital or outpatient surgical center, including electronically; however, a paper copy must be provided if specifically requested.

History: 2006 c 255 s 25

Effective: October 1, 2006

IV This language was added to make clear that providers can discount their services unless prohibited by federal law

62J.83 REDUCED PAYMENT AMOUNTS PERMITTED.

(a) Notwithstanding any provision of chapter 148 or any other provision of law to the contrary, a health care provider may provide care to a patient at a discounted payment amount, including care provided for free.

(b) This section does not apply in a situation in which the discounted payment amount is not permitted under federal law.

History: 2006 c 255 s 26

Effective the day following final enactment