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State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-SECOND SESSION

H. F. No. 4450

03/21/2022 Authored by Elkins
The bill was read for the first time and referred to the Committee on Health Finance and Policy

1.1 A bill for an act

1.2 relating to health care; requiring hospital pricing transparency; amending Minnesota
1.3 Statutes 2020, section 62J.823.

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

1.5 Section 1. Minnesota Statutes 2020, section 62J.823, is amended to read:

1.6 **62J.823 HOSPITAL PRICING TRANSPARENCY.**

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

1.9 Subd. 2. ~~**Definition**~~ **Definitions.** (a) For the purposes of this section, the terms defined
1.10 in this subdivision have the meanings given.

1.11 (b) "Chargemaster" means the list of all individual items and services maintained by a
1.12 hospital for which the hospital has established a charge.

1.13 (c) "De-identified maximum negotiated charge" means the highest charge that a hospital
1.14 has negotiated with all third-party payers for an item or service.

1.15 (d) "De-identified minimum negotiated charge" means the lowest charge that a hospital
1.16 has negotiated with all third-party payers for an item or service.

1.17 (e) "Discounted cash price" means the charge that applies to an individual who pays
1.18 cash or cash equivalent for a hospital item or service.

1.19 (f) "Estimate" means the actual price expected to be billed to the individual or to the
1.20 individual's health plan company based on the specific diagnostic-related group code or

2.1 specific procedure code or codes, reflecting any known discounts the individual would
2.2 receive.

2.3 (g) "Gross charge" means the charge for an individual item or service that is reflected
2.4 on a hospital's chargemaster, absent discounts.

2.5 (h) "Hospital" has the meaning given in section 144.696, subdivision 3.

2.6 (i) "Items and services" means any item or service, including individual items or services
2.7 or service packages, that could be provided by a hospital to a patient in connection with an
2.8 inpatient admission or an outpatient visit for which the hospital has established a standard
2.9 charge. This definition includes but is not limited to:

2.10 (1) supplies and procedures;

2.11 (2) room and board;

2.12 (3) use of the facility and other items, including facility fees; and

2.13 (4) services performed by physicians and nonphysician practitioners employed by the
2.14 hospital.

2.15 (j) "Machine-readable file" means a digital representation of data or information in a
2.16 file that can be imported or read into a computer system for further processing, and includes
2.17 but is not limited to XML, JSON, and CSV machine-readable formats.

2.18 (k) "Outpatient surgical center" has the meaning given in section 144.696, subdivision
2.19 4.

2.20 (l) "Payer-specific negotiated charges" means charges that a hospital has negotiated with
2.21 a third-party payer, and includes charges negotiated by a health plan company as a third-party
2.22 payer and charges negotiated by a Medicare Advantage plan or managed care plan under
2.23 section 256B.69.

2.24 (m) "Service package" means an aggregation of individual items and services into a
2.25 single service with a single charge.

2.26 (n) "Shoppable service" means a service that can be scheduled by a health care consumer
2.27 in advance.

2.28 (o) "Standard charge" means the regular rate established by a hospital for an item or
2.29 service provided to a specific group of paying patients. A standard charge includes the
2.30 following:

2.31 (1) gross charge;

3.1 (2) payer-specific negotiated charge;

3.2 (3) de-identified minimum negotiated charge;

3.3 (4) de-identified maximum negotiated charge; and

3.4 (5) discounted cash price.

3.5 (p) "Third-party payer" means an entity that is by statute, contract, or agreement legally
3.6 responsible for payment of a claim for a health care item or service.

3.7 Subd. 3. ~~**Applicability and scope**~~ **Required disclosure of written example.** ~~Any~~ (a)
3.8 A hospital~~, as defined in section 144.696, subdivision 3, and~~ or outpatient surgical center~~,~~
3.9 ~~as defined in section 144.696, subdivision 4, shall~~ must provide a written or electronic
3.10 estimate of the cost of a specific service or stay upon the request of a patient, doctor,
3.11 advanced practice registered nurse, or the patient's representative. The request must include:

3.12 (1) the health coverage status of the patient, including the specific health plan or other
3.13 health coverage under which the patient is enrolled, if any; and

3.14 (2) at least one of the following:

3.15 (i) the specific diagnostic-related group code;

3.16 (ii) the name of the procedure or procedures to be performed;

3.17 (iii) the type of treatment to be received; or

3.18 (iv) any other information that will allow the hospital or outpatient surgical center to
3.19 determine the specific diagnostic-related group or procedure code or codes.

3.20 (b) An estimate provided by the hospital or outpatient surgical center must contain:

3.21 (1) the method used to calculate the estimate;

3.22 (2) the specific diagnostic-related group or procedure code or codes used to calculate
3.23 the estimate, and a description of the diagnostic-related group or procedure code or codes
3.24 that is reasonably understandable to a patient; and

3.25 (3) a statement indicating that the estimate, while accurate, may not reflect the actual
3.26 billed charges and that the final bill may be higher or lower depending on the patient's
3.27 specific circumstances.

3.28 (c) The estimate may be provided in any method that meets the needs of the patient and
3.29 the hospital or outpatient surgical center, including electronically. A paper copy must be
3.30 provided if specifically requested by the patient or the patient's representative.

Subd. 4. ~~**Estimate**~~ **Required public disclosure of pricing information.** ~~(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.~~

(a) A hospital must make public:

(1) a machine-readable file containing a list of the hospital's standard charges, including payer-specific negotiated charges, for all items and services provided by the hospital in compliance with the requirements of United States Code, title 42, section 300gg-18, established under Code of Federal Regulations, title 45, part 180, as finalized on November 27, 2019, in that they are at least as transparent as required on that date; and

(2) a list of standard charges for shoppable services in compliance with the requirements under Code of Federal Regulations, title 45, part 180.60, as finalized on November 27, 2019. The list must provide a description of each shoppable service required to be included and must be made available in plain language and in a format that is easily accessible by the public.

(b) As part of complying with the requirements of Code of Federal Regulations, title 45, part 180, a hospital must make available to the public machine-readable files for the previous five years in a form and manner specified by Minnesota IT Services, in consultation with the commissioner of health.

(c) Failure to make standard charges public as required under this subdivision is grounds for regulatory action against a hospital. A hospital that fails to comply with this subdivision shall be subject to a fine of not less than a daily penalty of $300 for hospitals with 30 or fewer beds, a daily penalty of $10 per bed for hospitals with at least 31 and up to and including 550 beds, and a maximum daily penalty of $5,500 for hospitals with greater than 550 beds. Any fine issued under this paragraph is in addition to any civil monetary penalties

5.1 imposed by the Centers for Medicare and Medicaid Services under Code of Federal
5.2 Regulations, title 45, part 180. The commissioner may suspend a hospital's license if the
5.3 hospital fails to make standard charges public for two consecutive years.