2025 Health Care Affordability State Policy Snapshot

MINNESOTA

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HEALTHCARE VALUE HUB

State Has Active Legislation

State Does Not Have Active Legislation

The Health Care Value Hub ("the Hub") is proud to launch the 2025 Health Care Affordability Policy Snapshot ("Affordability Snapshot"). The Affordability Snapshot provides legislators, consumer advocates, regulators and other interested parties a tool to compare their state's health policies across other states.

The categories examined in this resource explore a variety of policy options that impact health care affordability. Policies were examined for whether they were active, implemented to a limited degree, or not active as of June 1, 2025. Sources for this information can be found in the downloadable **Data and Source Document available on the Dashboard page. Definitions and descriptions for each policy category can be found in the Glossary.**

The Hub offers online and hands-on support with staff dedicated to understanding health care policy and connecting advocates and other interested parties together to help build a patient-centered, high-value healthcare system. As a research-based organization, the Hub takes a comprehensive approach to improving affordability through policy analysis, translation, visualization, and collaborative engagement. We encourage advocates, legislators, and other stakeholders to share our findings to improve consumer health care affordability across the states.

Address Consolidation and Promote Competition

Consolidation Oversight

Policy	Status as of June 2025	Summary
Transaction Notification Required	Requires health systems or providers to notify the state of consolidation transactions	The Minnesota Attorney General must be notified of any acquisitions or conversions involving nonprofit corporations, corporations that hold assets for a charitable purpose, or nonprofit health coverage entity. The Attorney General and Commissioner of Health must also be notified of any transactions involving a health care entity with an average annual revenue of at least $80 million at least 60 days before the proposed transaction is completed.
Authority to Modify or Reject Consolidation Transactions	Does not have authority to approve, set conditions, or disapprove consolidation transactions	The Attorney General does not have the authority to approve or disapprove a transaction; however, he or she may bring an action in district court to enjoin or unwind a conversion transaction if the conversion transaction is contrary to the public interest.
Affordability Criteria included in Transaction Review	Includes consumer affordability or price growth in review criteria, approval conditions, or both	When determining whether a proposed transaction is in the best interest of the public, the Attorney General must consider whether it will reduce the affected community's continued access to affordable and quality care. Other factors informing whether a conversion transaction is contrary to the public interest include whether the conversion transaction will result in increased health care costs for patients or if it may adversely impact provider cost trends and containment of total health care spending. The Commissioner of Health may review and conduct an analysis examining the aggregate impact of health care transactions on access to or the cost of health care services, health care market consolidation, and health care quality.

State Has Active Policy or Program | Policy or Program Partially Implemented | State Does Not Have an Active Policy or Program | * No Source, or Limited Information Found

Address Consolidation and Promote Competition

Facility Fees

Policy	Status as of June 2025	Summary
Prohibits Facility Fees	⊗ State does not prohibit providers from charging any facility fees	
Facility Fee Transparency Laws	● State requires providers to disclose facility fees to consumers, requires off-campus outpatient departments to identify the physical location where care was provided on claims forms, or both	Hospital-based facilities must notify consumers regarding facility fees in multiple formats and circumstances, including before care is provided and in signage at the facility, that they may receive a separate facility charge, which may result in a higher out-of-pocket expense.
Limits Cost-Sharing for Facility Fees	⊗ The state has no laws that limit the amount a patient may be billed out-of-pocket for facility fees	

● State Has Active Policy or Program ◉ Policy or Program Partially Implemented ⊗ State Does Not Have an Active Policy or Program ✱ No Source, or Limited Information Found

Address Consolidation and Promote Competition

Anti-Competitive Contract Provisions

Policy	Status as of June 2025	Summary
Restricts All-or-Nothing Contract Provisions	⊗ No law restricting All-or-Nothing contract provisions	
Restricts Anti-Tiering and Anti-Steering Contract Provisions	⊗ No law restricting Anti-Tiering or Anti-Steering contract provisions	
Restricts Physician Noncompete Clauses	● Non-competes generally unenforceable or prohibited	In 2023, Minnesota became the fourth state to ban noncompete agreements, though the ban is not retroactive and still permits them in connection with the sale or dissolution of a business.
Restricts Most-Favored Nation Contract Provisions	● Law restricts Most Favored Nation contract provisions	Minnesota bans Most Favored Nation clauses in insurer-provider contracts, prohibiting guaranteed best rates or allowing contract changes if lower rates are offered elsewhere.

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Medical Debt Prevention

Balance Billing and Short-Term Insurance

Policy	Status as of June 2025	Summary
Prohibits Balance Billing for Ground Ambulance Services	⊗ Does not prohibit balance billing for out-of-network ground ambulance services	
Prohibits Short-Term, Limited Duration Health Plans	● State law has eliminated short-term, limited duration health plans	STLD health plans aren't explicitly banned in the state, but strict regulations have effectively removed them from the market.

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Medical Debt Prevention

Charity Care and Community Benefit

Policy	Status as of June 2025	Summary
Mandated Hospital Charity Care	⊗ State law does not require hospitals to provide free or discounted care to low-income patients	
Hospital Charity Care Screening Requirements	● State law requires health care providers to screen patients for Medicaid, Marketplace, or charity care eligibility before collecting payment	Minnesota hospitals are required to screen uninsured patients and those with unknown insurance status for charity care eligibility and assist them in applying if not found ineligible. Screening must occur within 30 days of service, and must be conducted in person or by phone.
Hospital Charity Care Notification Requirement	● State law requires health care providers to notify patients of charity care options before collecting payment	Minnesota hospitals are required to post notices about the availability of charity care in registration areas, emergency departments, and billing departments, and provide charity care policy documents and application forms on their websites in all applicable languages.
Hospital Community Benefit Reporting Requirement	● State law requires hospitals to annually report the amount of charity care provided	Minnesota hospitals must submit an annual report that includes detailed charity care information. This includes the amount of charity care provided, categorized by payer type and by inpatient or outpatient services; public and private funding received for charity care; and a copy of the hospital's charity care policy.

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Medical Debt Prevention

Reducing Financial Consequences

Policy	Status as of June 2025	Summary
Mandates Waiting Prior to Collections	State law prohibits sending medical debts to collections for a prescribed period (see note)	Minnesota hospitals may not refer medical debt to collections (including in-house or third-party collections, revenue recapture, etc.) until the patient has been screened for charity care, found ineligible, and offered a reasonable payment plan.
Limits on Liens or Foreclosures due to Medical Debt	State law does not prohibit initiating a lien or foreclosure to collect medical debt	Minnesota does not prohibit attaching a lien or prohibiting foreclosure to collect medical debt. However, Minnesota hospitals may not initiate any collections actions until the patient has been screened for charity care, found ineligible, and offered a reasonable payment plan.
Limits Wage Garnishment due to Medical Debt	State law exceeds federal wage garnishment protections for residents with medical debt	Minnesota does not have medical debt-specific limits on wage garnishment but uses an income -based sliding scale that prohibits garnishment for those earning below minimum wage, exceeding federal wage garnishment regulations. Additionally, hospitals cannot begin collection efforts until the patient has been screened for charity care, determined ineligible, and offered a reasonable payment plan.
Limits on the Amount of Interest Charged to Medical Debt	The state has not enacted a law to limit interest rates for medical debt	

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Curb Excess Costs in the System

Premium Rate Review

Policy	Status as of June 2025	Summary
Effective Rate Review per Centers for Medicare and Medicaid Services (CMS)	Has an effective rate review process	
Authority to Modify or Reject Premium Rate Increases	Has the authority to modify or reject premium rate increases*	Minnesota has the authority to approve or deny rate filings in the individual and small group market. We are unable to corroborate whether the state has approval authority over fully-insured large group health plans in 2025.
Affordability Criteria Included in Premium Rate Review	Does not incorporate affordability criteria into premium rate review	

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Curb Excess Costs in the System

Hospital Price Regulation

Policy	Status as of June 2025	Summary
Medicare Reference-Based Pricing	⊗ State does not use reference-based pricing tied to Medicare rates to regulate hospital pricing	In 2025, Minnesota considered a bill (SF 622) that would have permitted health carriers to offer a reference-based pricing health plan as a percentage relative to Medicare, but it did not pass.
Hospital Global Budgets	⊗ State has not implemented hospital global budgets	

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Curb Excess Costs in the System

Affordable Coverage

Policy	Status as of June 2025	Summary
Public Option	⊗ State does not offer an active public option insurance plan	Minnesota had previously passed legislation to establish a public option, anticipating that it would be available to the public in 2027. However, the state legislature repealed permission to seek federal approval for a public option during the 2025 legislative session, citing budgetary constraints.
Public Option Includes Provider Participation Mandate	⊗ State does not does not offer a public option, with or without a participation mandate	
Basic Health Plan	● State operates a Basic Health Plan	Minnesota offers a Basic Health Plan for low-income enrollees earning 133-200% FPL or legal residents earning 0-200% FPL who do not qualify for Medicaid. Notably, the state has authorized the Commissioner of Commerce to submit a 1332 waiver to the federal government related to implementing a Minnesota public option plan through the Basic Health Plan program and has allocated funds in its 2025 budget for that purpose.
State-Based Premium Subsidies	⊗ State does not offer supplementary state-funded premium subsidies	

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Curb Excess Costs in the System

Prescription Drug Pricing

Policy	Status as of June 2025	Summary
Biologic Substitution Laws: Prescriber Permission Requirements	State does not require express authorization for biologic substitution	
Biologic Substitution Laws: Prescriber Notification Requirements	Pharmacists are required to notify prescribers of biologic substitution	Pharmacists in Minnesota are required to notify the prescribing physician of a substitution within five business days.
Drug Purchasing Consortium	State participates in a drug purchasing consortium (see note)	Minnesota is a member of the National Medicaid Pooling Initiative.
Drug Coupon Prohibitions	State does not prohibit the use of drug manufacturer coupons*	
Medicaid Managed Care Organization (MCO) Carve Out	State Medicaid does not carve out any drug classes from their MCO benefits*	
Mandatory Generics in Medicaid Fee-for-Service (FFS)	Medicaid FFS programs and pharmacists are not required to substitute a generic version of a drug	

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Curb Excess Costs in the System

Prescription Drug Pricing

Policy	Status as of June 2025	Summary
Supplemental Rebate Programs	● Medicaid Pharmacy Supplemental Rebate Agreement (SRA) in place	
Drug Rebate Transparency and Reporting Requirements	● Pharmacy benefit managers are required to report rebate data to the state	
Spread Pricing Restrictions	● State prohibits pharmacy benefit managers from engaging in spread pricing	
Pharmacy Benefit Manager Reimbursement and Clawbacks	● State prohibits PBMs from retroactively reducing reimbursement to pharmacies (“clawbacks”)	
Cost-Disclosure and Gag Clause Restrictions	● State law prohibits gag clauses in pharmacy contracts	
Prohibits Copay Accumulator Programs	⊗ State does not prohibit copay accumulator programs	Minnesota lawmakers introduced legislation in 2025 that would have prohibited copay accumulator programs, however the bills did not pass.

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Curb Excess Costs in the System

Medicaid Costs

Policy	Status as of June 2025	Summary
Prohibits Balance Billing for Ground Ambulance Services	⊗ Does not prohibit balance billing for out-of-network ground ambulance services	
Prohibits Short-Term, Limited Duration Health Plans	● State law has eliminated short-term, limited duration health plans	STLD health plans aren't explicitly banned in the state, but strict regulations have effectively removed them from the market.

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Medicaid Services and Immigrant Coverage

Medicaid Administration

Policy	Status as of June 2025	Summary
Medicaid Managed Care (MCO)	State partners with MCOs to operate their Medicaid program	MCOs provide coverage to most Medicaid recipients including dually eligible recipients, children, adults, older adults 65+, and individuals with disabilities.
Medical Loss Ratio Remittances (MLR) for Medicaid Managed Care Population	State requires MLR remittances for its Medicaid managed care population	
Medicaid Site Neutral Payments	State has not enacted Medicaid site neutral payment legislation*	
Medicaid Vendor — Eligibility and Enrollment	State contracts with a vendor for Medicaid enrollment or eligibility*	
Integrated Medicaid-Medicare	State integrates Medicare-Medicaid to coordinate care for the dually eligible population	Minnesota has either or a combination of both highly integrated or fully integrated dual eligible special needs programs (HIDE/FIDE).

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Medicaid Services and Immigrant Coverage

Medicaid Covered Services

Policy	Status as of June 2025	Summary
Medicaid Coverage for Fertility Services	⊗ State Medicaid program does not cover infertility treatments or fertility preservation services	
Medicaid Coverage for Doula Services	● State Medicaid program actively reimburses for doula services	
Medicaid Coverage for Abortion Care	● State Medicaid program utilizes state-based funds to cover abortion care	
Medicaid Coverage for Transition-Related Care	● State Medicaid program explicitly covers any transition-related care for adults	
Medicaid Coverage for Hearing Aids	● State Medicaid program covers hearing aids for all adults	
Medicaid Coverage for Eye Exams and Glasses	◉ State Medicaid program covers only eye exams or eyeglasses but not both, or biannually or less frequently, or restricts coverage based on age or health condition (see notes)	Exams and glasses covered biannually.
Medicaid Coverage for Dental Services	● State Medicaid program covers preventive and diagnostic dental services, extractions, dentures, root canals, fillings, and crowns for adults	

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Medicaid Services and Immigrant Coverage

Medicaid Eligibility

Policy	Status as of June 2025	Summary
Medicaid Expansion	State has expanded Medicaid eligibility to 138% of the federal poverty level (FPL)	
Retroactive Medicaid	State retroactively extends Medicaid benefits 90 days prior to application date for all adult enrollees	
Adult Medicaid Continuous Eligibility	State has not authorized 12-month continuous eligibility for non-pregnant adult Medicaid enrollees	Minnesota received approval for 1115 waiver request to extend 12 month continuous eligibility to residents ages 19 and 20 only in an effort to extend coverage for children and young adults, effective January 1, 2025.
12-Month Postpartum Coverage	State has authorized 12-month postpartum Medicaid coverage	
Medicaid Available to People who are Incarcerated	State offers Medicaid coverage to justice-involved individuals while they are in a correctional setting	Minnesota has a pending waiver to provide Medicaid pre-release coverage for individuals who are incarcerated.
Medicaid Aged, Blind and Disabled (ABD) Asset Limits	State has expanded the asset limit for Medicaid for the Elderly and Disabled eligibility beyond $2,000 for an individual applicant and $3,000 for joint applicants	Minnesota Medicaid has expanded its asset limit to $3,000 for individual applicants and $6,000 for joint applicants.
Medicaid Aged, Blind and Disabled (ABD) Life Insurance Exemption	Life insurance exemption limits do not exceed $1,500	
Medicaid Aged, Blind and Disabled (ABD) Retirement Account Exemptions	State does not exempt retirement savings from Medicaid eligibility determinations	

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Medicaid Services and Immigrant Coverage

Immigrant Coverage

Policy	Status as of June 2025	Summary
From Conception to End of Pregnancy (FCEP)	Covers pregnancy-related services through the CHIP From-Conception-to-End-of-Pregnancy (FCEP) Option and post-partum coverage	Minnesota extends postpartum coverage to 12 months for parents covered by the From Conception to End of Pregnancy option.
Immigrant Children without a Five-Year Bar	State offers coverage for lawfully residing immigrant children without a five-year bar	
Pregnant Immigrants without a Five-Year Bar	Offers coverage for lawfully residing pregnant immigrants without a five-year bar	
State-Funded Coverage for Children Regardless of Citizenship Status	Offers coverage for children regardless of immigration status	
State-Funded Coverage for Adults Regardless of Citizenship Status	Offers coverage for adults regardless of immigration status	Minnesota's Basic Health Program, MinnesotaCare, is available to people with DACA status (nearly all of whom are adults) with income below 200% FPL. In 2025, Minnesota extended state-funded health coverage to income-eligible adults regardless of immigration status in January 2025. However, Minnesota paused enrollment for undocumented adults ages 18 and older on June 2025 and plans to end coverage by January 2026.

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Improve Oversight, Accountability, and Transparency

All-Payer Claims Database

Policy	Status as of June 2025	Summary
Established an All-Payer Claims Database (APCD)	State has a(n) all-payer or multi-payer claims database	
All-Payer Claims Database (APCD) Operated by the State	APCD is operated by the state	

Prescription Drug Affordability Board

Policy	Status as of June 2025	Summary
Established Prescription Drug Affordability Board (PDAB)	The state has an active prescription drug affordability board	Minnesota's Prescription Drug Affordability Board has the authority to review the affordability of certain drugs and establish upper payment limits.
Prescription Drug Upper Payment Limits	The state has established Upper Payment Limits for prescription drugs	Minnesota's Prescription Drug Affordability Board has the authority to set an upper payment limits and will reference the federally negotiated Medicare maximum fair price for any drug with a Medicare maximum fair price.

State Has Active Policy or Program | Policy or Program Partially Implemented | State Does Not Have an Active Policy or Program | * No Source, or Limited Information Found

Improve Oversight, Accountability, and Transparency

Price Transparency

Policy	Status as of June 2025	Summary
Service Cost Price Transparency Tool	⊗ State does not have a public-facing price transparency tool	
Prescription Drug Price Reporting Requirement	● Organizations are required to report prescription drug price information to a state entity	Drug manufacturers must submit data to the Commissioner of Health for drug price increases above a threshold and for new market entrances above the Medicare part D specialty-tier threshold. The Commissioner must share the reported information on its website.

Health Care Spending Oversight

Policy	Status as of June 2025	Summary
Health Care Spending Benchmark	⊗ State has not established a health care spending benchmark for providers, insurance carriers, or both	
Authority to Enforce Health Care Spending Benchmark	⊗ State has not established a health care spending benchmark, with or without enforcement mechanisms	The Department of Health of health analyzes escalating costs but does not have the power to fine or penalize hospitals or insurers.
Hospital or Primary Care Spending Oversight Entity	● State monitors and reports hospital spending, primary care spending, or both	Minnesota's Department of Health, Health Economics Program reports on hospital spending. In 2023, Minnesota passed SF 2995 requiring a report on primary care spending by February 2024 and establishing a Center for Health Care Affordability that may consider establishing quality and primary care spending standards.

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Reduce Cost-Sharing for Patients

Reduce Cost-Sharing: Prescription Drugs

Policy	Status as of June 2025	Summary
Waives or Reduces Cost-Sharing for Diabetes Medications	State has enacted legislation to limit cost-sharing for insulin, diabetes related equipment, or both	Minnesota's Insulin Safety Net and Continuing Need programs limit out-of-pocket costs for uninsured and underinsured residents. As of January 2025, the state also caps cost-sharing for a 30-day supply of prescription insulin at $25 and $50 for related medical supplies.
Waives or Reduces Cost-Sharing for Asthma Inhalers	The state has enacted legislation to limit cost-sharing for asthma inhalers	Minnesota limits cost-sharing for asthma inhalers at $25 per one-month supply per prescription. The state also limits the total cost-sharing for all related medical supplies used to treat asthma at $50 per month.
Waives or Reduces Cost-Sharing for Epinephrine Auto-Injectors	State has enacted legislation to limit cost-sharing for prescription epinephrine auto injector(s)	Minnesota caps cost-sharing for epinephrine auto-injectors at $25 per one-month supply per prescription. The total cost-sharing for all related medical supplies for allergies treated with epinephrine is also capped at $50 per month, regardless of the number of chronic diseases treated.
Waives or Reduces Cost-Sharing for Specialty Drugs	State has not enacted legislation to limit cost-sharing for specialty drugs	

Reduced Cost-Sharing: Behavioral Health

Policy	Status as of June 2025	Summary
Waives or Reduces Cost-Sharing for an Annual Behavioral Health Office Visit	State does not require private insurers to cover at least one annual mental health wellness exam without cost-sharing	

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Reduce Cost-Sharing for Patients

Reduced Cost-Sharing: Preventive Care

Policy	Status as of June 2025	Summary
Waives Cost-Sharing for Preventive Services Recommended by the U.S. Preventive Services Task Force (USPSTF)	State mandates private insurers cover USPSTF recommended preventive services without cost-sharing	

Reduced Cost-Sharing: Maternal and Reproductive Health Care

Policy	Status as of June 2025	Summary
Individual and Small Group Health Plans Required to Cover Fertility Treatment	The state does not require individual and small group health plans to offer coverage for in-vitro fertilization or fertility preservation services	
Individual and Small Group Health Plans Required to Cover Doula Services	State does not require private health insurers to cover doula services for enrollees	
Individual and Small Group Health Plans Required to Cover Abortion Services	The state requires individual and small group health plans to cover abortion services	

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Reduce Cost-Sharing for Patients

Reduced Cost-Sharing: Cancer Screening and Testing Services

Policy	Status as of June 2025	Summary
Waives or Reduces Cost-Sharing for Colorectal Cancer Screenings	State law requires insurers to cover colorectal cancer screening but allows cost-sharing	
Waives or Reduces Cost-Sharing for Follow-Up Colorectal Cancer Screening Exams	State law does not require coverage or waive cost-sharing for follow-up colorectal cancer screening exams	State law requires insurance carriers to cover routine colorectal cancer screening examinations. Legislation that would require insurance carriers in Minnesota to cover supplemental colorectal cancer screenings without cost-sharing was introduced in 2025, but the bill has not passed.
Waives or Reduces Cost-Sharing for Lung Cancer Screenings	State law requires insurers to cover lung cancer screening but allows cost-sharing	

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Reduce Cost-Sharing for Patients

Reduced Cost-Sharing: Cancer Screening and Testing Services

Policy	Status as of June 2025	Summary
Waives or Reduces Cost-Sharing for Cervical Cancer Screenings	State law requires insurers to cover cervical cancer screening but allows cost-sharing	Minnesota law currently requires health insurance carriers to cover Pap exams and preventive items and services as specified in the current recommendations of the United States Preventive Services Task Force and in the comprehensive guidelines supported by the Health Resources and Services Administration without cost-sharing, which includes cervical cancer screening. However, if relevant provisions in the Affordable Care Act are substantially changed it is unclear if the cost-sharing prohibitions will cease.
Waives or Reduces Cost-Sharing for Breast Cancer Screenings	State law requires insurers to cover breast cancer screening but allows cost-sharing	Minnesota law currently requires health insurance carriers to cover mammograms and preventive items and services as specified in the current recommendations of the United States Preventive Services Task Force and in the comprehensive guidelines supported by the Health Resources and Services Administration without cost-sharing, which includes breast cancer screening. However, if relevant provisions in the Affordable Care Act are substantially changed it is unclear if these consumer protections will remain in place.
Waives or Reduces Cost-Sharing for Supplementary Breast Cancer Screenings	State law requires insurers to cover supplementary breast cancer screening with no cost-sharing	If a health care provider determines an enrollee requires additional diagnostic services or testing after a mammogram, a health plan must provide coverage for the additional diagnostic services or testing with no cost-sharing, including co-pay, deductible, or coinsurance.

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Reduce Cost-Sharing for Patients

Reduced Cost-Sharing: Cancer Screening and Testing Services

Policy	Status as of June 2025	Summary
Waives or Reduces Cost-Sharing for Prostate Cancer Screenings	State law requires insurers to cover prostate cancer screening but allows cost-sharing	
Waives or Reduces Cost-Sharing for Ovarian Cancer Screening	State law requires insurers to cover ovarian cancer screening but allows cost-sharing	
Waives or Reduces Cost-Sharing for Biomarker Testing for Cancer	State requires coverage of biomarker testing for cancer screening but allows cost-sharing	Insurers in Minnesota are required to cover biomarker testing to diagnose, treat, manage, and monitor illness or disease if the test provides clinical utility. Each fiscal year, an amount necessary to make payments to health plan companies to defray the cost of providing coverage under this section is appropriated to the commissioner of commerce.

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